HIV Health & Human Services Planning
Council of New York
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MR. LESIEUR: Despite the people in the back room, we're going to start. Good morning everybody. My name is Matthew Lesieur. I'm a community co-chair of the Ryan White Planning Council, so I want to welcome everyone here. Very impressive showing. I'm glad that we have a pretty good participation here.

So I just want to sort of provide this meeting in the context of the bigger role of the Planning Council and why are we here in the first place.

So with the exception, I would say [indecipherable]. The Ryan White Planning Council is the only federally funded program that I know of that is mandated by legislature that as a condition of the city or jurisdiction getting its funding, that the elected official must establish an independent planning body made up of people affected with HIV as well as community members and that they have sole authority over how to allocate and set priorities for this funding.

It is different from anything else. Different from community development block grant; different from [Indecipherable]; different from defense department. Any other federal funding you can think of, when the money gets into the jurisdiction, it's left up to government officials, bureaucrats, whatever you want to call them to decide internally how to spend that money. That's been that way since the bill was passed in 1990 and the City received its first award in 1991 if I think I have my years right.

So this has been a long history here and this is something we very much cherish.

Carrie Fisher is going to talk for a moment [indecipherable] the context of how this actual meeting came into being. I just sort of wanted everyone to be aware of the importance of today in the context of making decisions over how this planning body is going to proceed to set priorities for its roughly a hundred million dollars in federal funds it gets.

And the one thing that has sort of become a constant I would say every since the departure of Bill Clinton as president is that we're not getting any new money. We're lucky if

we're going to receive relatively stable flat funding and that is the new normal. If anything, we received some cuts over the last couple of years, so we're lucky if we get the same amount of funding from year to year.

So the Planning Council has really, really started to ask itself, is the current allocation of resources that we currently have the most effective and efficient usage of our money? Are we doing right by the consumers who live in the boroughs and three counties north of us? Are the allocation of resources effective? And are there in equities in the delivery of resources between the City and State three counties north of us? Is everybody getting their fair share? Is everybody receiving the same quality of care across the EMA?

And so, this -- you know, we come to a point now where as Carrie is going to explain, we really wanted to have a much larger dialogue with the entire community about some key issues about socioeconomic factors, around housing and trying to think out of the box and where we can do better delivering services and asking ourselves is our priority setting process on the right track.

And with that, I'll leave it to Carrie Fisher.

MS. DAVIS: Carrie Fisher, I like that.

MR. LESIEUR: I'm thinking Star Wars, what can I say?

MS. DAVIS: Oh yes. Hi there. My name is not Carrie Fisher and I don't play one on TV. My name is Carrie Davis and I'm the Co-Chair of the Needs Assessment Committee of the HIV Planning Council and I also work at the Lesbian, Gay, Bi-sexual and Transgender Community Center on Thirteenth Street.

So, as Matt mentioned, in deciding on about how we're going to spend our money, we need to understand need. And the Needs Assessment Committee is one of nine committees that are part of the HIV Planning Council that look at different issues. We focus on managing the need.

We work in strong concert with the New York City Department of Health and we felt that looking back on how things had changed over recent years, in particular around HIV prevention and treatment with the advent of the actually HIV and Aids strategy back in 2010, that we wanted to look at need a little differently. We had already

created a needs assessment, but it was time to think more publicly about different issues that were coming forth; looking at housing, socioeconomic factors and co-factors and issues like hepatitis C. So we thought we would look, take a step back and do a public event to try to share more with you all with what's going on in a way that might be received and understood a little differently.

So we've created today's event, again with full work -- as part of the Needs Assessment Committee, but also with the Consumer's Committee. They gave us a lot of feedback about the questions we should be asking, the issues and some of the concerns they had about different aspects of what's going -- what we're going to be talking about today and we hope that we've captured all of that as the day goes forward.

I want to talk about our format really briefly. Each panel will open with a five to eight presentation of data by a staff member from the New York City Department of Health. These are going to be the only formal presentations that are going to be made today. The rest of it will be a panel discussion that will be moderated. We're

going to try to keep to our time schedule. I've already had a conversation with all the moderators about moving us forward today.

The panelists and moderators were given an opportunity to include information in your packets, so some of the presentations have been added to those packets and feel free to look at those and use those as you need to.

And so finally, I just want to close by acknowledging and thanking those people that work so hard in this, of course, the Needs Assessment Committee. My Needs Assessment Co-Chair, Daniel Casionos [phonetic] is out of town right now, could not be here, a long planned trip to the Amazon. He's having a good time. His thoughts are with us. As well as the Department of Health Staff that really helped put this together; Nia Rothschild [phonetic], Jan Carl Park and all the other people we work with at the Department of Health who really have given us tremendous support in this.

So with that, I'm going to hand the baton over to our moderator of the first panel, Eric Rudy. Can the first panel take their seats up here?

MR. RUDE: Hi. My name is Eric Rude. I am the Director of Viral Hepatitis Policy and Development at the New York City Department of Health and Mental Hygiene and I'd like to -- actually before we get going with the panel and before we even introduce everybody, we're going to start with a data presentation on the co-infected population in New York City. So I'm going to hand it over first to Jacinthe Thomas at the Department of Health.

MS. THOMAS: Good morning everyone.

SEVERAL: Morning.

MS. THOMAS: My name is Jacinthe Thomas. I'm a Senior Research Analyst with the Caring Treatment, Research and Evaluation Unit within the New York [indecipherable] Aids and Prevention Control.

Today, I'm going to share with you the result of an analysis that we did looking at HIV and HCV co-infection. So before I talk more about the analysis that we did, I want to give a little bit of background about HIV and HCV co-infection.

There was a study that was conducted for which the data are shown on the left side where they look at the advance events of anti-HIV drugs.

So they look at depths in a [indecipherable] of patients who were treated with anti-HIV drug. And what they found is that liver related disease, liver related death was the most frequent cause of non-AIDS related death.

They also look at among those who died of liver disease. What they found is that the risk of death, of dying from liver disease was highest among patients co-infected with HCV and Hepatitis B. So I should mention that throughout the presentation, I'll use the acronym HCV when referring to Hepatitis C.

So this graph, it show the HCV care continuum. This is very similar to the HIV care continuum, but what it does, it show -- sorry. It shows the estimate of the number of HIV infected -- HCV infected patient achieving each step along the HCV care continuum from those who have currently -- those who are currently infected with HCV and then, as you can see, there is a continuous drop throughout the, along the HCV care continuum.

And if you look at on the last step of the HCV care continuum, when we look at of all the first person estimated to be infected with HCV in

New York City, less than ten percent achieve sustained biological response, meaning that they are clear of the HCV virus.

So now to get to the analysis, the PCSI match that we use for this analysis was made possible by the program collaboration and service integration project at New York City DOHMH and that what the project had allowed us to do is to share data between programs and we were able to share data across different diseases area, such as TB, viral hepatitis, HIV and STDs.

And so using the PCSI match result, we looked at three different data sources that were included in the PCSI match. We looked at the ESHA data where the ESHA stand for electronic system for HIV/AIDS reporting and evaluation, which is the main reporting system used for Ryan White part A to report on Ryan White part A clients.

So clients were included in the PCSI match where a client was served for any part of 2010 to 2014. And that were match through the HIV registry.

Now the HIV registry includes all people in New York City diagnosed with AIDS or HIV infection and in the PCSI match, we included all

those from 2010 to 2013 -- 2000 to 2013. And then in the PCSI match, we also included hepatitis C registry data, which include all people diagnosed in New York City for the same time period as the HIV registry which is from 2000 to 2013.

We wanted to exclude a number of -- we excluded all the deaths that occur and were reported as of December, 2015 to us from this analysis. We also, when we look at certain information, which I'll be discussing shortly, we -- in terms of looking at Ryan White information for this analysis, we used the data which was most recently reported in the HIV registry as of September, 2015.

As of July, 2015, HIV, HCV or any result has been reported, negative HCV or any result have been reported to the Health Department and so we use this information for the analysis using data that was recently reported as of January, 2016.

In looking at the ESHA data, we looked at the updated substance use information in ESHA and insurance information for Ryan White clients using data reported as of January, 2016.

Now onto the good part. Who is co-infected with HCV and hepatitis -- HCV and HIV?

So using the data from the PCSI match result, we look at all patient living in New York City who are considered to be alive as of December, 2014 and for this, we use two definition when looking at co-infection.

We use the ever chronically infected with HCV, which is that the way we define chronically infected with HCV is that they needed to have a HCV antibody positive test in the HCV registry.

In terms of currently, chronically infected, we looked at those who were HCV -- that had an HCV antibody positive or a flag in the registry as -- that they were flagged in the registry as chronically infected and they didn't have a negative INE [phonetic] -- HCV INE result at the Ryan White, meaning that they still had the virus.

For this, we wanted to kind of get a better sense of the patterns in terms of looking at some of the criteria that are used when looking at treatment, so we look at recent hard drug use.

For this, we look at the population serve in 2014, so we look at all clients in the PCSI match result which was 2014 was the most

recent result that was -- the most recent data that were included in the PCSI match result for Ryan White. And we look at -- so for the co-infected, they needed to be serve in 2014. They were flagged in the registry as being in the HCV registry as being currently infected. And then we also look at those, we could only look at those that had none missing information for insurance.

So when we defined, we said hard drug use, so for the ESHA data, we only looked at any information that was in ESHA for this population from 2013 to present. So we didn't look at any information prior to 2014 when looking at the recent hard drug use.

And then in terms of the [indecipherable] information which we, which was from the HIV registry, we looked at any information that was reporting on [indecipherable] in 2014 through 2015. So for the [indecipherable] information, what we did is we look at the latest information that they had in the registry and we saved as an anchor and then we look at six months prior to that anchor and look at whether or not they had [indecipherable] and if they didn't have any [indecipherable], we use that anchor as the

[indecipherable] information in order to look at -- sorry -- in order to look at whether they had detectable [indecipherable] in the last six months or undetectable [indecipherable] which we define as detectable [indecipherable] which is [indecipherable] greater than fifty.

And then we look at those who had recent hard drug use or detectable [indecipherable]. For those that had neither -- so they didn't have neither reported, neither recent hard drug use or detectable [indecipherable] reported, so that's the information.

When you look at the insurance information with this information, the neither reported, so they didn't report any hard drug use or any detectable [indecipherable]. It was about thirty-two percent for all the, we're looking at all insurance information, none missing information.

And then we had the unknown drug use and no detectable [indecipherable] which is a little bit lower.

One thing that I want to mention. When we're looking at recent hard drug use, one thing that we have not been able to do is that in Ryan

White -- in ESHA, the information on hard drug use is not reported from all service categories, so we have a lot of unknown, none reported is the category that we mentioned above. So you see there were like more than sixty percent for which we don't have, we don't know anything about this information. So we don't have any information on this.

And also, I want to mention, when you're looking at the neither reported, again to go back to this neither reported, this is the category that we think would benefit most from getting -- from treatment for the co-infection, for hepatitis C.

And also, I want to mention that the Medicaid begin to cover the new HCV treatment so the data that we use here is from 2014, so we weren't able to look, to take into consideration the new treatment information in this analysis.

And so, also I want to mention about the [indecipherable] and on insure. So those are our clients in each year that reported as having [indecipherable] or un-insure. However, we do not have information from the [indecipherable] program because this information is being held by the

state, so we don't have information on clients who were [indecipherable] program.

So in talking about treatment consideration, they are like multiple barriers to care including treatment because before treatment can be considered, the patient needs to be in care and so there are things that need to be considered such as lacking the patient to care and also provider education to help the clients get the help that they need.

Also, to give a brief summary because the table that we just looked at had a lot of information. When we look at co-infected clients served in New York City in 2014, we see that in terms of insurance, eighty-nine percent received public health insurance. And with public insurance, it's Medicare, Medicaid, military and other public. While only nine percent were uninsured or reliant only on [indecipherable].

And then when we -- to summarize about the recent hard drug use, only twenty percent reported recent hard drug use. However, as I mentioned before, the information was only on a number of clients, for seventeen percent.

In terms of [indecipherable] status, we

found out that fifty-three percent had at least one detectable, which is greater than more than fifty [indecipherable] in the last six months. So there are a number of assistance that are available for, in terms when considering treatment for HCV, including drug company patient assistance. Also helping the clients navigate to help them receive the insurance coverage that they need. There are a lot of partnerships between providers and speciality companies and then also as the supports for provider who has the experience of treating patient with substance use.

To conclude, at the Department of Health, we think that they are the help available to -- that the majority of HCV patient could be, should be able to, should be able to get treatment from, through the healthcare system and we are available to help and assist on a case by case basis.

Thank you.

MR. LESIEUR: Thank you very much. You can leave that up. Thanks. If you don't mind, I'm going to refer to some of your slides. These are excellent, excellent data. Thanks Jacinthe.

You know, this kind of data analysis is

vital to programs like Ryan White and [indecipherable] and I know that this data analysis is something that you're going to be using -- oops, excuse me -- as you do your needs assessment.

And I did want to just point out a couple of things because we use things like this treatment cascade. This is something that every state in the country has, has created that is a real good illustration of the critical gaps that exist in treatment for hepatitis C, both in the co-infected population and in the mono-infected population. And you'll just see that, at the very end here, there are very few people that are being cured. This is very few people, both with HCV and also co-infected HCV and HIV and what this says is that we need help.

We need help with linkage to care specifically because you see that huge drop in people who are infected and aware of their infection. So we need people tested and then we need -- there's another huge drop in people who are eligible to be treated, treated and then there's, you know, right here, it's a little bit stable. We can get people treated and cured once

they're in treatment. We have the drugs now. The really good drugs that will cure people. So once we get them into treatment, that's fine. We just need to get them into treatment. That's the problem.

So what this analysis is showing us is that there are a lot of people who are co-infected who can't access treatment and that's the purpose of today's discussion. And a lot of the problem exists in that access to care, so what I'd like to do is, at that, is introduce our panelists, so from left to right, I'd like to introduce Thad Smith from AbbVie who is the Director of the Patient Access Programs.

Then we have Dr. Shuchin Shukla who is in charge of the Project Inspire Program at Montefiore Medical Center.

Paul Bolter, the evaluation -- I'm sorry -- the creator of the -- gosh, Paul, I'm not sure what your --

MR. BOLTER: I haven't created much.

MR. LESIEUR: Paul, what is your, what is your title?

MR. BOLTER: Community Allocation Education [indecipherable].

MR. LESIEUR: Thank you very much. At the American Liver Foundation.

And then we have Melvin who is a community advocate. Excellent.

And then Tracey Griffith, the Hepatitis C Program Manager at Suny Downstate.

I want to thank you all very much for being here today. It's really important to hear from community members like yourselves, professionals and consumers. So let's get started with some questions. What kind of barriers and let's see, Melvin, I'd like to start with you.

First of all, before we even get to barriers, would you like to tell us what your story is with HIV co-infection?

MR. SHEPHERD: How long do I have?

MR. LESIEUR: Well, you know what, I'm going to be generous. Why don't you start and pick up one of those microphones and tell us all about yourself.

MR. SHEPHERD: Oh. I'll try to do this as briefly as I can.

MR. LESIEUR: All right. Excellent.

MR. SHEPHERD: My name is Melvin Shepherd. I'm sixty-one years old. I'm co-

infected with HIV and Hepatitis C.

MR. LESIEUR: Would you put your microphone up?

MR. SHEPHERD: All right. I've been peer educated at ASC/NYC for fourteen years. Today I stand here in good health thanks to my doctors and my support at ASC/NYC.

For many different trainers and workshops and events concerning HIV and hepatitis C, today I am more informed about my situation and the things I need to do for myself to make it better.

I've learned the important facts that my doctors are a very important part of my life. It is important for me to take my medication and for me to get my -- it's very important for me to get my proper rest and keep my doctor's appointment. Sometime I may feel, find things in my labs that I don't understand. I'm so glad I have ASC to help me understand them.

From the year 2006 to 2007, I was on --

MR. LESIEUR: You're going to have to keep the mic up.

MR. SHEPHERD: -- oh. I've been doing [indecipherable]. I was at [indecipherable] for

eighteen months. I went through the side affects for one day. The longest day of my life. I had hot flashes for three minutes. I had cold flashes for another three minutes for three hours. I was in my wellness room at ASC/NYC. The drug staff member there, Mr. Mondo Blue talked me into, talked me through it. He told me to relax and reminded me that I was around friends and co-workers and that I would be safe.

And for the next eighteen months, the only challenge I think I faced was taking that needle, the interferon, once a week. And I'm so glad that, you know, I can walk from [indecipherable] back to ASC and felt comfortable because I was a peer there. I was still able to work and everything and, you know, try to help other people.

MR. LESIEUR: I'm sorry. Melvin, you were on the interferon treatment, weekly injections. Is that right?

MR. SHEPHERD: Yes, yes, yes.

MR. LESIEUR: And you're cured now?

MR. SHEPHERD: No, no. That's never part of it. This was in 2006 to 2007. I stayed on it for eighteen months because they gave me an

extra six months. The treatment was for twelve months. They gave me an extra six months to make sure it was gone because I was undetected.

Two years after being through that and then nine months after all the treatment, it came back in me. It came back. And I wasn't -- I mean, I don't know how it got there. I practiced safer sex. ASC taught me a lot of things and I know to protect myself at all costs is one of them.

Skip to let's say 2010. I went to another hospital. I went to Sam's Clinic, Saint Lukes, one hundred fifty-ninth Street and my doctor, Abigail Zula [phonetic], she was very good. She monitored my hep C. My HIV was still undetectable. I was told in 2015 about a new treatment that appeared to work in people of color. My doctor put me on that list for people that really needed it and by -- and this, in October of 2015, I was able to get that drug, Harvoni.

Let's say the first week, the first week of it, I went through all the side affects; dizziness, weakness, confused and at that time, I believe I consulted one of our new drug staff at

ASC, Ms. Daniel Barnes and I told her about all my symptoms and I told her when I took my medication. And she said, "Well, take it at night." And I couldn't believe it. It worked. I had no symptoms after that.

And so today, let's say three months later, I took the Harvoni from October to December. Right now, I'm off it. I'm undetectable and my HIV is undetectable and let's say ASC helped me a great deal with the support and the health information and referrals that I received. I'm in good shape and I hope to remain that way.

I would like to thank the panel. I would like to thank Ms. Nan [phonetic] for having me and I would definitely like to thank my staff at ASC for coming here to support me and for, you know, keeping me, keeping on.

MR. LESIEUR: Excellent Melvin. I appreciate that.

I just have a follow-up question for you. So you said you're undetectable now.

MR. SHEPHERD: Yes.

MR. LESIEUR: For how long.

MR. SHEPHERD: Three months now.

MR. LESIEUR: All right.

MR. SHEPHERD: Oh no, two months.

MR. LESIEUR: All right. Dr. Shukla, how long is it -- do you mind picking up a microphone? How long before Melvin would be considered cured?

DR. SHUKLA: Three months after the last pill.

MR. LESIEUR: Okay. So, I'd say Melvin, you're well on your road to calling yourself a cure, right?

MR. SHEPHERD: Maybe.

MR. LESIEUR: All right. Excellent. That's a success story. So you were able to get Harvoni which is the newest, one of the newest directly acting anti-virals.

MR. SHEPHERD: Yes.

MR. LESIEUR: Many people, however, can't. It's one of the newer drugs. We were very fortunate to have these new, the new very high priced drugs on the market in 2014, however access to these drugs is very limited. And I wonder if someone on the panel can describe what the limitations are. Dr. Shukla, would you be able to discuss some of the conditions that exist for

people?

DR. SHUKLA: Sure. So I think for co-infected patients, it hasn't been the biggest problem. There's a real long process in getting medication from insurance companies. And as a physician, usually we don't have time to spend, you know, probably up to an hour or two of paperwork and phone calls to get it done, but if you get it done either with help or yourself, usually it gets approved.

I think the harder situations are for mono-infected, so people without HIV that have hep C, they often get denied depending on the insurance company.

However, it's still a pretty long process and it's a barrier as a doctor. If I didn't have help doing it, I probably wouldn't be doing it.

MR. BOLTER: May I say something?

MR. LESIEUR: You may, Paul. Thank you.

MR. BOLTER: Hi. Good to hear you, Melvin. Thank you.

I had hepatitis C for thirty years. I got diagnosed in 2001 and I didn't get cured until 2014 and in that time, I was on treatment seven

different times and what happened was is that there were so few hep C drugs for someone that was mono-infected that if one drug didn't work after six months, they took me off of it. Then I had to wait two years and then I would go on another study and it was like that through fifteen years.

Fortunately, my F1 score never went past a zero one, but for many, many people with hep C, that's not the case. So what happens is, is while they're waiting to be approved for a new drug or waiting for a drug that they can financially afford based on their race, gender, HIV status and what have you, disease does progress and sometimes rapidly.

So that's like one of the biggest barriers, especially if there are other co-morbidities. If I had diabetes, if I had kidney disease. All these other factors take place in what treatment I'm going to get and then you have certain providers that will only prescribe one medication or one protocol. And that's not the best protocol for everybody, so patients often have to shop to find a doctor that will give them the medication without these included barriers.

MR. LESIEUR: Often on their own without

assistance.

MR. BOLTER: Without navigation.

MR. LESIEUR: Right.

MR. BOLTER: Because sometimes the navigation isn't in place.

MR. LESIEUR: Right.

MR. BOLTER: So once the person is diagnosed, linkage to care has to happen right then and there within the same facility not refer out to linkage to care because you'll lose the patient.

MR. LESIEUR: Exactly. Tracey, you run a program at Suny Downstate. What kind of assistance do you provide for patients who are on hepatitis C treatment?

MS. GRIFFITH: So, at Downstate, we have a program funded through the Department of Health where it's specifically to link people who are co-infected to care.

So I, in my team, I have a peer and I have a case manager, a navigator and there is myself. So between the three of us, we're able to kind of go out into the community in Brooklyn, test people and get them into care.

So typically for my program, we -- I can

probably get someone on treatment within a month, two months usually tops. All of my patients that have been referred to me, I have gotten medication for. It takes a little time, like the doctor said, but I'm able to do it. And it's -- one of the key things with hep C is that you do need support. So if there's only a provider, it's much, much harder for the patient to get treatment versus at least having a nurse or a case manager or someone in the team to help navigate the system.

MR. LESIEUR: You said navigation is key?

MS. GRIFFITH: It is key because if we have -- I have encountered many people who, and many doctors, who are trying to treat hep C and they just don't know what to do, where to go or where to send the patient and if you have someone who can actually -- who's like a peer, a peer is great especially since they've been through the process, they know what it takes, they know what they need to do. That peer is able to help other patients kind of get through the system, understand what to expect, what labs need to be done so that they can get the treatment.

So it's really important to have at least a nurse or a case manager around that can help the person, the patient, figure out a plan for them.

MR. LESIEUR: Creating a care plan.

MS. GRIFFITH: Right.

MR. LESIEUR: With a multi-disciplinary medical team is appropriate.

MS. GRIFFITH: It's appropriate. It's ideal.

MR. LESIEUR: Uh-huh.

MS. GRIFFITH: It's not always the perfect set up for everyone. It's not something that everyone is able to have, but having the multi-disciplinary team is a hundred percent best.

MR. LESIEUR: Right.

MS. GRIFFITH: In my opinion.

MR. LESIEUR: And you also mentioned peer navigation.

MS. GRIFFITH: Right. So we have -- a lot of programs are now developing peers. The Department of Health also has an HCV peer navigation program and they're able to assist patients or people who are hep C positive to find them a provider that actually treats the virus, so

they're able -- so you're not really -- the patient is just not left out by themselves trying to figure out what to do. The Department of Health does have help out there to help people find where they can get care throughout the city.

MR. LESIEUR: And these are peers like Melvin who would have gone through treatment and then been able to help other folks.

MS. GRIFFITH: Right.

MR. LESIEUR: Melvin aids community service center --

MR. SHEPHERD: Yes.

MR. LESIEUR: -- has programs like that. Am I right?

MR. SHEPHERD: They have a lot of them. A few program --

MR. LESIEUR: Would you mind picking up a microphone?

MR. SHEPHERD: Yeah.

MR. LESIEUR: Thanks.

MR. SHEPHERD: Yeah, they have a lot of support books and I think that's very important because a person like me, myself, can sit with other people and talk about our problems and feel very open about sharing and that's a big deal.

You know, just to have that environment.

MR. LESIEUR: Exactly. Other kinds of support are necessary. Dr. Shukla was discussing how a lot of the paperwork that goes into authorizing patients who need the treatment in order to get the insurance approved, insurance reimbursement improved.

Thad, you help patients with this -- you have a patient assistance program with AbbVie, can you describe the assistance you provide?

MR. SMITH: Sure. Good morning everybody. Can I have like two minutes for a quick aside?

MR. LESIEUR: Sure.

MR. SMITH: Okay. So at events like this, I reflect back on my history with HIV and about thirty years ago, as a then student at a military college, I stumbled on this HIV event at the Washington Mall. I don't know if -- I'm sort of older than some of the people in the room, but there's this thing called the quilt. I don't know if any of you remember that, but that was my first impression and my first learning about HIV and now here I am about thirty years later working the drug company that's helped advance treatment of

both HIV and HCV and as I'm sure everybody knows, HCV is now killing more people than HIV. So made a lot of progress, but there's still a lot of work to be done.

So with that, my responsibilities at AbbVie that I oversee are patient assistance programs that serve people in the United States across all of our different disease areas, including both HIV and HCV.

We offer a whole set of services to help people access their medicine which can include helping people in doctor's offices with navigating the insurance hurdles, like prior authorizations and then appeal support.

And then we offer co-pay assistance for people who have commercial insurance and still need some help.

And then the area that I'm most focused on is free medicine for people that can't afford it most of whom don't have -- can't access it, ideally because they don't have insurance, but what we found in this disease in particular, there are so many people that even with insurance, they're just not able to access it because of insurance restrictions primarily related to

[indecipherable] scores. Some also related to drug and alcohol use as well, or preferences for certain drugs by health plans.

So what we try to do is if people can't access their medicine through insurance is they most often qualify for free medicine and then they can get their course of therapy delivered to their house or to their doctor's office from our service providers.

MR. LESIEUR: So I imagine that if someone is uninsured and possibly not approved through [indecipherable], they would be able to get their medication through your patient assistance program?

MR. SMITH: It's a case by case situation, but if they're -- generally, if they're not approved and they've gone, gotten the initial -- the necessary denials, they would be approved.

MR. LESIEUR: Right. Okay. Excellent. Yes, Paul?

MR. BOLTER: At the American Liver Foundation, we have an affiliation with the PAN [phonetic] Network, which is also a Patient Assistant Network. We ask people to call our, call into our call line. It's 1-800-Go-Liver and

we get over almost six thousand calls last year alone just hep C related. People from Egypt, all over the world, looking for assistance with medication and services here because it's more assessable here than it is in a lot of other countries, so this project [indecipherable].

There's a lot of different programs out there as well that help supplement you along the way because some people with insurance still have a three, four, five thousand dollar co-pay.

So there's a lot of different programs outside of like what Abbie is doing and Abbie has been one of the leaders in continuously supporting patients with hep C. I just wanted to add that.

MR. LESIEUR: Thanks Paul. Paul, while we have you, what other services for patients who are having difficulty accessing treatment or navigating the healthcare system can you provide at the American Liver Foundation?

MR. BOLTER: At the American Liver Valuation or Foundation?

MR. LESIEUR: Did I say valuation? Sorry. The American Liver Foundation.

MR. BOLTER: My role is to provide education and support and advocacy to many of the

agencies that are in this room today from Staten Island to northern New Jersey.

So what we do is go around and we educate staff, case managers, linkage to care specialists, peer navigators, patient navigators, doctors, admin on liver disease, liver wellness, especially viral hepatitis and hepatitis C and also co-infection.

We can't talk about HIV these days without talking about hep C and visa versa. They're like the new companion diseases that are out there today.

So what we do is provide education on what kind of medications are available. Not everybody is going to get Harvoni. Not everybody is going to go on these drugs that are available. So when we see the commercials and we hear the messages, we have to always remind people that yes, this commercial comes on at eleven/twelve o'clock at night and everybody looks sad in that commercial, but that doesn't have to be you. So we try to reduce some of the stigma within the hep C community because there's a lot of stigma attached to this disease, especially from patients living with it.

So we just try to provide education and support around understanding the virus, what the virus can do to you and how to prevent it from causing further disease and damage, so if that means we go to Washington and we work with the House and legislation on some bills that are out there, then we do that.

And on a local level, we work with companies like ADV and the LGBT Center, the Department of Mental Health and Hygiene on trying to provide patient navigator network, which we're actually having a meeting today, which is also folks that are in this line of work of education and support, come together and talk about best practices and how to support the challenges they have within their agencies on helping people navigate through the health system.

So a lot of different things like that.

MR. LESIEUR: Excellent. Thank you.

I'd like to return a little bit to the restrictions on treatment and I wanted to ask Dr. Shukla, if I could, we -- I don't know that we addressed restriction on HIV viral load. Can you describe or can you just discuss that briefly what that restriction is?

DR. SHUKLA: So I'll start with saying that this is a moving target for doctors and agencies and everything in terms of every insurance company has their own rules. They change them constantly. They aren't informing you necessarily. They might post on their website. They might not. So it's -- it takes a lot of legwork just from that perspective.

So on top of that, I would say my experience as a treater has been that, yeah, if someone has -- so I misspoke I guess in the beginning saying that usually people with co-infection, meaning HIV and hep C, usually get approved. That's true, but I think one of the barriers is if their HIV has been detectable maybe in the last six months -- it depends on how much data the insurance companies request when you send in the prior authorization.

And other reason is if they have, you know, some insurance companies actually ask for a U-tox, a urine drug screen, which is absolutely not in line with medical recommendations, but the insurance companies make these rules and have denied patients meds, lifesaving meds because of that.

Those are the main reasons I see co-infected patients being denied.

So a positive U-tox, I would say pretty clearly has no reason for denial. There's some evidence that you have a slightly reduced cure rate if you're taking these really great meds and you are abusing alcohol or maybe more specifically alcohol, but you can still get cured with a really, really good chance of curing your virus.

Positive viral load, I saw that on the list of questions and I tried to do a little research. I don't think there's much data on cure rates on someone's HIV viral load is detectable, meaning their HIV is not under control and they're taking hep C meds. I would assume the concern is that the patient is not adherent with their HIV meds and that's their reason an insurance company might not want them to have hep C meds. Which I think is somewhat legitimate, but yeah I guess I'll say it's somewhat legitimate, but I don't have a strong feeling either way about it, I guess.

MR. LESIEUR: Well, I think you're right. It's a moving target. I -- this is something that has been a constant concern of mine

since the drug utilization and review board of the office of, the state office of health insurance had instituted these restrictions in 2014 when Harvoni came on the market.

It's been a constant state -- cause of concern because there really is no medical rationale for this.

But I do have good news. In my discussions with the state, I'm constantly speaking with the state office of health insurance and my colleagues at the state department of health and if you recall, and you may not be aware of this, but in response to these really restrictive guidelines and these exist not in New York state only, but all across the country, the Centers for Medicaid and Medicare Services, CMS, wrote a letter to every state office of Medicaid and Medicare. No, I'm sorry, Medicaid. And told them that they need to be aware of what's going on in their own regarding these restrictions. They need to not be discriminatory. They need to be, they need to make sure that they're -- not just their own Medicaid fee for service program, but also all of their Medicaid managed care programs are not overcharging and their prices are all in

line.

So our office of Medicaid -- or our Medicaid program in New York state is actually surveying each one of their Medicaid programs right now as we speak and they're going to have a definitive list of what all of their restrictions are.

So you were saying it's a moving target and you're right. Each one has their own list of what their restrictions are. They may on Monday do one thing and on Tuesday, do something entirely different. So we will finally know what they are, what the restrictions are once the survey is completed.

But I think too that because the market is changing, because now we do have more drugs on the market and the price may be reduced that the restrictions may not be so important any more either. So we'll see.

Let me just take a quick look at the time. We may be ready for our Q&A period. A couple more minutes?

So, Melvin.

MR. SHEPHERD: Yes.

MR. LESIEUR: Let's talk about your life

post cure. You are now a man who has the freedom to do whatever you want. What is it like being, you're a peer navigator for Aids Service Center.

MR. SHEPHERD: Yes.

MR. LESIEUR: And how is it, how does it feel after having hepatitis C for how many years you had it with your HIV? What is -- how does it feel different to you?

MR. SHEPHERD: First of all, I've been diagnosed with HIV since 1986 and I think I found out about my hep C in 2005 and upon learning these things that's happening in my life, it was game changers. I listen to people. I took advice. And I got with the program, ASC/NYC that really helped me stay on track and so I try to be a role model, you know? I don't think I'm better than nobody. I just listen now, you know? You bump your head enough, you learn.

MR. LESIEUR: Excellent. Tracey, what -- do you feel that some of the programs that you've instituted at the -- are you -- by the way, is it the STAR program that you work in?

MS. GRIFFITH: Right. The STAR program.

MR. LESIEUR: The STAR program at Suny Downstate. Are some of the programs that you have

that are successful, are they scaleable [sic] to the rest of the city and state, do you feel? Or is it too financial -- is there -- is money and finances and funding an issue?

MS. GRIFFITH: Funding is definitely an issue. Without the funding, we wouldn't be -- I wouldn't be able to have a team. I would be doing the prior [indecipherable], education, the counseling. I would be doing everything.

MR. LESIEUR: Uh-huh.

MS. GRIFFITH: So definitely having the funding to bring on people to help you get the prior authorization or to support the doctors is important.

It's also important to -- it helps us go out into the community and test people for hep C. We weren't -- I was not able to do that post a year ago before my grant.

So it's -- funding is a hundred percent a necessity in a lot of -- especially in the STAR program, but a lot of other programs within the state to help go into the community and get the patients to come into care because we cannot expect that the patient will just come to us. We have to go find them, basically. And it's hard.

It's very difficult to try to find the patients. We, we -- I've encountered more mono-infected patients than co-infected recently, but we're still able to treat everybody.

MR. LESIEUR: That's excellent.

MS. GRIFFITH: Right. So you know, I've done a lot. I've done pretty much all of the PAs for my patients, so it takes me a long time to do it, but I'm able to do it. You know, I do get -- I'm in I think seven or eight appeals right now, doing two state appeals. You know, there are a lot more insurance companies that are easier to deal with versus others.

With the viral load, I've encountered, with the hep C viral load, if they're under eight hundred thousand that the insurance company has actually denied it saying that they were not sick enough. So I've encountered that and I've had to write letters to get them approved.

Yeah, it just makes my, it makes it longer to do, but I'm still at it. I still do it.

MR. LESIEUR: It's a burden.

MS. GRIFFITH: Right.

MR. LESIEUR: And it costs money. And in summary, I just wanted to point out there are

two, two real barriers and one is the funding, obviously, to find patients and to navigate them. Again, that will alleviate this barrier, this huge gap here between knowing that you're positive for hepatitis C and not knowing that you're positive for hep C.

The other barrier is once they're in treatment or rather getting them into treatment is that other barrier. People who are not able to get into treatment because they are denied treatment is the next barrier. So that's something to consider here during this panel. Those two barriers.

And you know, I've been doing hepatitis work for fifteen years and we had no treatments for a very, very long time and once those new wonderful treatments came out, we in the business thought it was all over. Everyone was going to be cured. Once you do, you cure a majority of people in the population, you have that ability to then realize that you can -- if you cure everybody or cure the majority, the virus will eventually you know, leave the population.

But because then the price was -- most people were priced out of it, then on top of that

have the insurance barrier added to that where people couldn't access the treatment. That was the, that you know, that prevented us from that dream, realizing that dream.

So here we are back in ten years ago where we're seeing it off in the distance again. Seeing the end of this epidemic off in the distance, but you know, we may be on the road again. As the prices drop, as the treatments become better and continue to get better and insurance companies realize that people need the drug, money becomes available, we'll hopefully see the end of this.

So right now, I'd like to thank the panel. Can we give everyone a real big hand?

And we have plenty of time for questions. I have several microphones.

FEMALE: Hi, I have a question. Are there any data at this point on reinfection rates of co-infection or just hepatitis C?

MR. LESIEUR: Dr. Shukla, would you like to answer that?

DR. SHUKLA: Okay. I should have studied before I came. There is data. I'm not incredibly familiar with it. The rate is quite

low and so some people use this as an argument of why a person who injects drugs should not be given meds, but my argument would be treating that person prevents that person from infecting others, so you know, in the HIV world, we treat as prevention. I think that's sort of the mantra moving into the hep C world. But I don't have the exact number off the top of my head.

MR. LESIEUR: Yes, sorry.

MALE: If I could just give a little insight on that. A lot of information I'm hearing about reinfection is due to lack of education, so when someone is finished with the twelve weeks of treatment and then another twelve weeks, they're given the cured diagnosis, they're given a message hopefully from their doctor that after two weeks of stopping medication to dispose of your personal hygiene products; nail clippers, fingernail files, toothbrush, razors. I shave my head. Any of that stuff that may contaminated blood, that you may have used prior to clearing the virus.

And watching out for nail salons and pedicures and certain things like that where other implements may have been contaminated and that's like a standard message that's given out from a

lot of providers, so a lot of people miss that message, but that has impact on some reinfection.

MR. LESIEUR: There's a question here.

FEMALE: I guess it's a comment and a question. One thing that I didn't hear come up was the utilization of syringe exchange programs? And the fourteen of those across the city and in treating active drug users, that that's a really important step to make sure that you're linking people back to syringe exchange program so even if they are using while they're on treatment or they continue using even when they're done treatment to make sure that the providers are having that kind of conversation with them to know where they should go, know what they need, know how to stay safe, know how to prevent reinfection.

And I heard a lot about patient navigation, but not necessarily linkage to syringe exchange programs.

MALE: I think that's part of it at the patient navigator network, many of the people that come to the meeting work for SEPs.

FEMALE: Uh-huh.

MALE: So they do have a really active role and they're very visible in the community.

Thank you.

MR. LESIEUR: Over here.

MALE: Yeah, hello. Good morning. Up to ninety-seven percent cure rate is formidable and it's very promising and encouraging, however, a cure is not a vaccine and it highlights what Melvin mentioned. It highlights [Indecipherable] reduction and educating. One serves an education about how to prevent transmission of HIV -- HCV as well.

Thank you for bringing that up in front of us.

I would like to ask a question to Dr. Shukla. If a patient is unable to access treatment, how would you feel about referring this patient to a clinical trial?

DR. SHUKLA: I don't know. Do you have an answer to that? I mean, clinical -- so the meds that exist all work really well, so in terms of a clinical trial, I don't know if that would be my best solution for a patient who's unable to access medication. I, you know, the few patients who can't access medication whether it's because of their U-tox or their viral load or under insurance, in some cases I would refer to like a

program like [indecipherable], a patient assistance program.

But yeah, I don't know much about clinical trials. Sorry.

MALE: I have another one here.

MALE: Yes. This is for Mr. Smith. You have an acronym behind your name, AbbVie. I'd like to know what that stands for.

MR. SMITH: Oh yeah. No, that's the a reference to my employer, AbbVie, the drug company. I don't have any acronyms after my name. I want one, but I don't have one.

MR. LESIEUR: Anybody else?

MR. JOSEPH: My name is Howard Joseph from Exponents. I think maybe more Melvin, I want to share. I had hepatitis C for fifty years. I stood on the sidelines with the interferon because I distrusted what the pharmaceutical companies were claiming and what the department of health was claiming that they were having cures of sixty to seventy percent with the interferon treatment. I didn't see that in my friends who were being treated. It was like one out of ten were reaching what we call the cure.

Last year at this time, I went on the

Harvoni -- I wanted to go on the Harvoni treatment and I'm on Medicaid and I'm working full-time, I'm on Medicare. And they were hitting me with a co-payment of fifteen thousand dollars for the three month treatment and I just said, "Hold on. Hold on." But one of the foundations that Gilliad [phonetic] I think, put together, at some point they had these foundations that will pick up the co-payment and this foundation picked up my co-payment and I went forward with the treatment and I got to say, it was a piece of cake. I won't to put that out here. Harvoni made the cure a piece of cake. I took my medications for three months and at the end of ninety days or sixty days afterwards, I did another blood test. They told me I was cured and that foundation sent me a medal.

FEMALE: Hi. Good morning. Thank you all for your presentations.

There's a practice that insurance companies do that's called adverse tiering where they automatically put certain drugs for certain diseases in particular tiers that have more expensive co-pays, etcetera. And I just, I'm trying to -- I just want to clarify in my own mind

that the insurance barriers that you all spoke about in terms of hep C, that is not adverse tiering. Correct? The insurance barriers that patients face who are hep C infected are because of eligibility and because of lack of insurance to begin with.

MS. GRIFFITH: It varies. It kind of varies. It's a little bit of what you're saying. It's a little bit of what we're saying. It really depends on the insurance company. They -- I've encountered in the last, I think, three weeks where we've written for one prescription, one particular medicine and the insurance company has come back and said, "No, we cannot give that medication. We have to give something else." But the medication that was written was because there was a particular issue, medical issue, that warranted that medication and so a lot of insurance companies are now trying to force us to write for one versus the other because one is a little bit cheaper than the other one.

So it, it does happen. It can and it happened -- it just happened to me last week twice, so right now, currently, I'm appealing it. Right.

FEMALE: It's against the law.

MS. GRIFFITH: Right. It is, but the insurance company doesn't really care. So, --

MR. LESIEUR: This is what, this is what that letter that I was describing to you was about.

MS. GRIFFITH: Right.

MR. LESIEUR: They are trying to get away with something and it's up to the state office of insurance to not let them do that.

MS. GRIFFITH: Right. It's hard, but you know, it takes a long time. I know probably in your practice it takes a long time. It just, it's just all about being diligent and keeping at it. I feel, I really do feel sorry for doctors who are in a practice by themselves and don't have at least one other person to help because that doctor -- the insurance company will always deny the prescription and the doctor will say, "Well, you can't get it." And I've encountered a ton of patients in that category.

So it's really, it's very difficult. It's really important to have a team or at least external support.

DR. SHUKLA: And just to piggy back on

what Tracey was saying and your question. So there's -- at this point, let's say about five or six different regimens depending on the genotype.

MS. GRIFFITH: Uh-huh.

DR. SHUKLA: So and all of these meds work really well with cure rates let's say above ninety, ninety-five percent depending on a few things.

MS. GRIFFITH: Right.

DR. SHUKLA: But these meds are not equal specifically, just from a medical standpoint in terms of drug interactions.

MS. GRIFFITH: Uh-huh.

DR. SHUKLA: So this, I would say, is sort of a barrier that's specific to co-infected patients in that the HIV medicines often interact in pretty significant ways with hep C medicines and if someone has lived with HIV for decades, they might have been through a couple of different regimens where they can't really switch from this medicine to that medicine and so with all due respect to AbbVie, AbbVie is actually one of the medications that has some more side affects, outside of its drug interactions.

So the problem becomes, you know, these

insurance companies will make a deal with this drug company or that drug company to say this is the one we prefer, this is the one that only doctors can get --

MS. GRIFFITH: Uh-huh.

DR. SHUKLA: -- when it's not really in the patient's interest.

MS. GRIFFITH: Right.

DR. SHUKLA: It's really in some maybe stock holder's interest or financial person's interest.

MS. GRIFFITH: Uh-huh.

DR. SHUKLA: And also folks that are non-responders to treatment will fall into another category, but usually sometimes the rule on the street is you get one prescription a lifetime for your hep C because it's such a challenge. You know, people advocate to get referrals processed and you get the drugs, but then if you fall out of care, non-compliance, adherence or the drugs don't work, what do you do then with this patient that you spent eight months trying to get on care?

So sometimes the insurance companies create that challenge as well. It's not maybe the patient's fault the drugs didn't work, but how do

we get them another prescription after the first one was so hard to get?

MR. LESIEUR: We have time for one more question.

MR. OCEANS: Thank you. Jeff Oceans from the Department of Health. What legal or political actions are actually being taken right now to make these drugs more assessable or actually to make them cheaper?

MR. LESIEUR: Wow. That's a very good question.

MALE: There's a lot of answers to that.

MS. GRIFFITH: Who will take that one?

MALE: No hope.

MR. LESIEUR: Right now, the latest news is that Washington State just filed a lawsuit against its State Medicaid program. Indiana is about to sue their state Medicaid program. Connecticut last year threatened to sue their state Medicaid program. You know, that might work.

So those are, you know, large actions. On the ground though, I think there's also actions that, that we can do at the grass roots level and in New York State, there is a group called the New

York State Hepatitis C Coalition that's actively working on this issue. You know, there are things you can do to lobby your legislators or lobby the Medicaid office or lobby the Drug Utilization Review Board. They have meetings quarterly and you can, you can apply, you can actually -- you can voice your concerns with the Drug Utilization Review Board. Now whether they listen to you or not is, you know, it depends. But if there are enough of us, they might hear you.

So those kinds of things can happen. I think, unfortunately, however, time is really our best, our best -- fortunately or unfortunately, it's our best friend because I think, again, the market is really starting to change because of competition so that might be the best answer.

MALE: Just one more question I have if I may? I'd appreciate it.

Harvoni is a fairly new drug. I know the patent would last for X amount of years, so how long before the patent will expire so you can start doing some generics?

MALE: I think it's seven to ten years for a patent. Ten years, right?

MS. GRIFFITH: It's about ten years for

a patent.

MALE: In ten years, like maybe a third of people with hep C will be dead. I mean, it's -- I just want to point something out about this, the drug cost conversations.

So you know, I've seen studies, you know, if we estimate there's two point six million people in America with hep C. If we treated all of them in one year, it would wipe out pretty much the entire healthcare budget. So we can't really just make this accountable to state Medicaid offices. Really, the drug companies are holding a gun to the American taxpayers' head. There's not too many treatments we can do as doctors that are as life saving and have such a mortality benefit as treating and curing hep C and if we had maybe a different patient population that weren't maybe more minority and more drug users, I'm sure the conversation would be different. But really, this is a conversation about social justice and patients aren't getting access to care for absolutely non-medical reasons.

So I mean, I run a program that has a pretty decent budget, but we've joked that maybe it's worth using that money to buy a cruise ship

and bring all these patients to a third world country where these drugs are tremendously cheaper from the same drug companies. I mean, why is America paying so much for these meds?

There's a hundred million dollars in the Ryan White fund. That's like a thousand patients to cure. I mean, that money wouldn't go very far considering how expensive these meds are, so I think that's a conversation that also needs to be had.

MR. LESIEUR: Excellent, excellent way to end. Thank you.

MANY: [Many talking at once as it sounds as if meeting was adjourned].

MS. BARRETT: Hello everyone. Can we get back to our seats please, so we can begin? Okay. So as we get started, that was a great presentation that we had before on hep C. And we have more to present, so if we could just all get situated so we can begin. It's a lot of information that we're trying to crunch in a very short time.

Okay. So we're going to begin our second panel, but before we begin, so this panel is on socioeconomic vulnerability with an emphasis

on employment and economic well being. It's a big title and a lot of information, right?

Okay. So we're going to -- so as we did before, we're going to have a very short data presentation and a lot of information I must say that's in your packet as well about this topic that we're going to present. So we're going to have Mary Irvine. She was here before. Okay, here we go. That's going to do a quick data presentation that we can use to start our panel presentation.

Thank you.

MS. IRVINE: To make this shorter. All right. How's that? My boots? Maybe it's my boots.

So I'm just going to try to give you a little local context in terms of the Ryan White part A data that our providers diligently report to us through E-share.

In the background, you pretty much already I'm sure are aware of employment. We're thinking about partly because it's a key resource for becoming financially stable and insuring housing stability and just economic self sufficiency and as the sort of packet indicates,

the current treatments for HIV are effective enough that more and more people are in a position to go to work, go back to work while continuing to manage their health.

And the research that's out there about employment among people with HIV suggests that there are health advantages, as well as sort of quality of life benefits to employment. And then thinking about it in terms of part A, our program -- the program, of course, addresses all kinds of social services and health services needs for low income people living with HIV, but at this time, it does not fund any kind of job placement, job training or other assistance related to employment.

That said, while we can't use Ryan White funds specifically to support employment services among our contractors, there are ways in which our providers may be able to support employment goals of their clients through referrals and linkages to other programs that are funded for that.

And then in terms of the data, in the summer of 2013, a couple of people in my unit were working on looking at E-share employment information which is limited. You'll see what we

have on it. But just, we were particularly interested in seeing, you know, as a first look, what's associated with being employed among our Ryan White part A clients and what's associated with becoming employed if you started out not employed. And that's just because some of those associations, there's factors that we can find that are related to employment are one sort of weigh-in to thinking about what are interventions that we might do. Where might be intervene to sort of increase these things that currently seem to be associated with employment.

So looking at the data overall for HIV positive adult Ryan White clients at that time, this was just really a year and a half of E-share data at the time, so 2012 and half of 2013, fifteen percent of the Ryan White part A population was employed either part-time or full-time. We consider either part-time or full-time the same. And then in terms of those -- we're really interested in paid employment, so among those who were not reported to be either out of the work force, which could be because they retired, they're a student or a full-time care giver or not reported to be doing unpaid work,

only unpaid work.

We found higher odds of being currently employed for pay among clients who were educated at or above high school level, enrolled longer in Ryan White services, which is interested, stably housed, not surprising, younger, male, foreign born and showing a higher CD-4 count. So CD-4 at or above three fifty or for some of these people not having CD-4 count which could just be that you were newly diagnosed or not recently in care. I think we had like a six month look back for that CD-4.

And this is adjusting for several demographic and clinical characteristics, so when you hold those equal, these are the things that are independently associated with being employed currently.

And then we wanted to look specifically at people who started out not employed when they were enrolled in the Ryan White part-A program on which we had data and see what was associated with becoming employed. Now, just to reiterate, we only had a year and a half of data, so this was not a long stretch of time during which people might sort of transition into employment. It's a

very short window of time for people to become employed.

With that said, there were seven percent who did become employed in that period and so between their baseline assessment and a later assessment in Ryan White.

And we found higher odds of becoming employed among clients who were educated at or above high school level, enrolled longer in Ryan White, stably housed, younger, male and foreign born. So all the same characteristics that were associated with being employed currently in Ryan White were associated with becoming employed if you started out unemployment.

And however, CD-4 was the one thing that wasn't significant in this smaller sub-group analysis and that may have just been because of the smaller end.

So just to sum up, any kind of employment, part-time or full-time, for pay was rare at fifteen percent. The odds of employment, you can think of the odds as the likelihood or the probability of something divided by the probability of it not happening, so the chance of being employed divided by the chances of not being

employed.

The odds increased with each level of increased education or enrollment duration, so there's this sort of gradient effect, like the more education you had, the more likely you were to be employed. The younger you were, the more likely you were to be employed. And also true for the longer you were enrolled in Ryan White, the more likely you were to be employed, so there's sort of gradient effect.

And then among those who were not working at baseline and they were reassessed for employment, seven percent gained employment and the factors associated with gaining employment were pretty much the same as those that were associated with being employed in the first place.

So kind of when we're thinking of these factors that are associated, one of the critical distinctions to make is factors that we can impact. What are the things that we actually might be able to change or that a person might be able to change over the course of their lives?

So demographics, often not that changeable, but education, housing and enrollment duration, all things that can change for an

individual and that we might be able to do something about. Particularly in Ryan White, we should be thinking about the housing association because housing assistance is something that Ryan White does pay for. And the retention of clients in Ryan White services since clients who were in services longer seem to be more likely to be able to be employed and become employed.

And then finally just to reiterate, this analysis is limited by a short time frame, so we didn't get a lot of data on those transitions into employment. At this point, we can go back and revisit that and see how that looks.

We also didn't have information at the time on sort of ability to work, so disability or ability to work and that's something that some of you may know we've been collecting in Ryan White just since the start of 2014. So ESHA now has a couple of years of data on sort of key disabilities and that we can look at in relation to employment and think about people who we would particularly target to become employed.

So I think that really sums up what we've seen so far in Ryan White. There's obviously much more to look at in the future.

Thank you.

FEMALE: Wow. Thank you, Mary. That was a lot of information in a very quick time. I do appreciate it.

But with our panelists, they're going to talk more about what's happening right now in our current situation and go back to some of the information that we see on our slides, so as our panelists come up, I'll ask Carrie, Cathy, Aron and David and Mark. You guys know who you are. Don't be shy to come up. I'm on a first name basis with all of you all.

You know, as our panelists get settled and we're thinking about employment and income, you know, it just goes back to an Aretha Franklin song, No Romance Without My Finance. Okay. Because I got my mind on my money and my money on my mind. Okay. It goes hand in hand. Right? Okay.

So I could have -- so we can start from my right going over to my left. If we can have the panelists introduce themselves please.

MR. MISROCK: Hi. I am Mark Misrok [phonetic] and I am with the National Working Positive Coalition.

MR. PIERSANTE: Good morning everybody. My name is David Piersante. I'm the Director of Eligibility for the New York City HIV/AIDS Services Administration.

MS. DAVIS: Hi there. I introduced myself earlier, but I'm Carrie Davis. I'm the Chief Programs and Policy Officer at New York State's LGBT Community Center and also co-chair of the Needs Assessment Committee.

MR. COBBS: Hi, my name is Aron Cobbs. I'm a Community Educator at Lambda Legal.

MS. BOWMAN: I'm Cathy Bowman and I am the Director of the LGBT and HIV Unit at South Brooklyn Legal Services.

MS. BARRETT: Thank you guys. And for those of you guys who don't know who I am, my name is Fay Barrett. I'm the Director of Support Services at the Ryan Center. So welcome and thank you again to my panelists.

All right. So I have a bunch of questions and we want you to be respectful to answer our questions precise enough and also to leave enough time for our audience to ask some questions because this is really a big hot topic when we're talking about income and employment and

getting back into the work force and we know that there's a lot of factors that prevent individuals from going back into the workforce.

So Carrie, I'm going to pose this question to you. What are some of the biggest fears of HIV positive clients and HIV positive transgenders who are thinking about going back to the work and who have no work experience?

MS. DAVIS: So, I'm going to re-frame this question because I think there's, there's the issue of people going back into the workforce, but with the transgender community, a lot of people have never really been in the workforce. And so for that community, it's often looked at very differently.

I think -- I've been working in the area of HIV and with trans services for seventeen years now and ever since I started this work, the focus was on HIV with a minor focus on other health issues. But, and we now have this magnificent national strategy playing out in the way we fund services, biomedical prevention model that really should be successful if adequately funded and resourced, but the most recent research on transgender people and HIV -- and prep, shows that

basically states that prep is not effective with transgender people compared to placebo.

So what -- they're not saying that the biology of prep doesn't work with transgender people. What they're saying is that there are other factors that prevent transgender people from adequately staying in a course of care that allows prep to work.

So in a sense, certain communities -- and this is not unusual and it's not exclusive just to transgender people. We often see a similar issue with young [indecipherable] of color, for example, in New York City. What we're seeing is the relationship of factors that place people at risk keeping them from engaging in care.

So from my perspective, it's not an issue of return to the workforce, but actually preparing people to be in the workforce at a very foundational level.

MS. BARRETT: Okay. Mark, do you want to piggy back from what Carrie was saying about placing people back into work and the barriers that people face when going back to work?

MR. MISROK: Sure. I want to just sort of follow up on Carrie's comments. You know, I

think that the -- you know, I worked for fifteen years as an employment specialist for the population that included a number of people who were transgender who I observed experiencing some of the worst discrimination in the work place of any workers in communities that were more progressive than the average in this country.

And so I think that just in terms of understanding the implications when people can't access living wage, healthy, protected mainstream employment, the options that are left to people include some of the most risky and dangerous of ways to get by financially and so I do think that it's important that we really zero in on the fact that not just, but certainly for the transgender community, we need to understand that really scaling up efforts to address employment needs is essential to both HIV prevention and HIV care, so I appreciate that focus.

In terms of other needs of people who have worked and are looking to go back to work or those who have not. You know, the fears include, huge fears about losing benefits or even the ability to understand what in the world happens to my benefits. We live in one of the better

developed service systems in this country and it's very difficult for people living with HIV to understand exactly what would happen if they started to get work earnings to any of their benefits. The information is not made clear and available and public to people living with HIV and I think if you check around the room, few of us who are service providers or policy makers actually feel like we've been, had the opportunity to become well equipped to understand the implications related to these important safety nets for our clients. So little wonder that we as a system have done very little to really support and encourage people to consider and pursue employment.

MS. BARRETT: True.

MR. COBBS: If I can -- I'm sorry. If I can just piggy back a little bit off of what --

MS. BARRETT: All right. Go ahead.

MR. COBBS: -- Mark and Carrie said.

And this appreciation for understanding a reentry into the workforce for in particular trans people of color, as Carrie mentioned, I think that we have to understand sort of nontraditional sort of forms of employment or

work, in particular when it comes to trans people of color. And so understanding that people are sort of operating and navigating survival economies and you know, engaged in work and are being paid for certain services and -- or not paid. There's certain things that people, in particular trans people of color that I work with in community are doing all sorts of amazing things, but within a volunteer capacity.

And so when it comes to applying for jobs, we need to understand that a lot of people who are working in community, especially for larger or smaller non-profits have a number of transferrable skills and a number of things you can gain from traditional employment, but because they don't have the respectability of being able to list that on a resume per say, it's not appreciated.

So I just wanted to say that work is, expand the definition of work a little bit. Thank you.

MS. BOWMAN: And I would just also add from the legal perspective, it really is hard to overstate the level of discrimination that trans people experience in particularly in the

employment realm, but I think interacting with all the systems that we all have to interact with all the time. And so you know, we actually do have very good laws in New York City and they do cover gender identity, but I think making sure that those laws are really enforced is important.

I think, as you were saying, it's like even in these communities that we think of as being among the more progressive I the country, they're horrible. Like people are treating horribly everyday and I think really making sure that we are enforcing the discrimination laws that we do have and really making these systems work for the people that they're designed to work for is incredibly important.

MS. BARRETT: Okay. So, we know that as you guys mentioned the lack of availability of work, especially you were talking about for transgenders and people who they're mostly volunteering. So what are some of the vocational gaps that we see? What are some of the resources that we need in our society to mend those gaps? Go ahead Aron.

MR. COBBS: Well, I'll speak from, I guess my perspective. At Lambda Legal, we work to

-- and it's a constant effort to, you know, make sure that our staff, our volunteers, our interns reflect our values and you know, the issues that we represent. So hire, interview. There's very pragmatic things that you can do. Actually take a look at the resumes or, you know, take a chance and have an interview and a conversation with people. Provide opportunities for leadership development, you know, for internships.

I'm working within a coalition here in New York City called the Kiki Coalition that does very intentional direct outreach to youth who may be housing insecure or homeless or transient, but who are involved in the ballroom community and that's a community that certainly knows a lot about, you know, resilience and supporting itself.

So there are lessons to be learned from the community. We just have to listen about what their needs are.

I also just say that, to put it more concretely, I think that in terms of achieving or sort of closing those gaps, we have to be very mindful of the discrimination that Mark mentioned and just be intentional, you know. Some of the organizations that, you know, represent these

causes aren't necessarily employing trans women of color and putting them in leadership positions or allowing them to lead movements that they've already been -- or efforts that they've already been, you know, sort of under [indecipherable], but haven't been necessarily given credit for.

So I think that visibility, opportunity and all of those things.

MS. BARRETT: Okay. Go ahead.

MS. DAVIS: So right now, our strategy for HIV is to make people less infectious. But I don't believe when you speak to the people that we're serving that less infectious is good enough.

So when we think about holistically addressing HIV from a structural level, we can't expect Department of Health biomedical prevention to carry a load that's far beyond its capacity to handle. We need to think of addressing poverty as a primary intervention for dealing with HIV. So as long as we make HIV just a medical issue and ignore the -- we knew this back in the nineties and eighties when we were doing organizing that HIV was not just about pills, but it's become that.

And I'm impressed by how effective prep

is, but when I talk to people about what they're seeking to accomplish in their lives, prep isn't what they're seeking to accomplish in their lives. They have much larger goals and their ability to stay on prep is predicated for their ability to successfully accomplish those other goals and I think if we -- if there's anything we can do as a movement it's to focus on increasing resources in other areas, not just around biomedical prevention.

MS. BARRETT: Okay. Mark, you wanted to say something?

MR. MISROK: Just I do think that that's critically important to understand.

I also think that we need to today understand that there has been a shift very recently out of HRSA. The HIV/Aids Bureau released a policy clarification notice earlier this month. It's PCN1602. That actually is an update of the articulation of what is or is not an allowable use of Ryan White HIV/Aids program dollars and together, alongside that PCN was a set of FAQs for the PCN1602 that was a set of questions that HRSA decided were the important questions to ask. One of which actually was, Is

vocational therapy an allowable use of funds under the Ryan White HIV/Aids program?' And it says, Yes. Vocational therapy is allowable use of funds under the rehabilitation services category.'

So we've lived for a long time under this cloud of understanding that Ryan White can't go there when it comes to employment and that's why we've got a system that's so dramatically under developed in terms of even assessing, much less beginning to address employment needs.

MS. BARRETT: Exactly.

MR. MISROK: And so we need to make the shift to looking at what we can do.

MS. BARRETT: Thank you. So true. You know, we all know what the governor said that we want to reduce or eliminate HIV by 2020. Everybody knows this, right? We hear about 2020.

However, we all know also that if I can't afford to eat or to live somewhere or to pay my bills, I'm going to do whatever is necessary to get my income to do that. Right? And we all know the correlation if what I'm going to do if I'm doing risky behaviors, what that's going to lead to. It's not going to end the epidemic in 2020.

So David, what is the financial impact

if I am going back to work and it's going to affect my benefits?

MR. MISROK: Okay. First let me just give a quick little kind of data summary. And keep in mind, everything that I'm going to say now is HASA specific, which means that the benefits that I'm going to speak of require that someone become a HASA client and by that I mean somebody as of today has to be CDC defined AIDS and/or HIV symptomatic. We're hoping that's going to change sooner than later. I'm sure many of you already know about the, about the HASA for [indecipherable] and you know, where we're looking to open up HASA for individuals that are low income and just HIV positive alone, which would include a much larger group of the City's population right now, which unfortunately are excluded.

So right now, we're servicing about thirty-one thousand cases, a little over thirty-one thousand. Of that thirty-one thousand, about half of them are on some type of federal income, be it either SSI or SSD and we have, as of January of 2016, we have approximately nineteen hundred clients who have earned income, either through

part or full time employment.

So what I do when I educate HASA clients again because one must be a HASA client to benefit from this earned income disregard is that I let an individual know that we have through the assistance of New York State OTDA, which is Office of Temporary and Disability Assistance, we have the ability to discount ninety dollars of their gross monthly income and then fifty percent of that and that's a pretty big, that's a pretty big chunk. That income is completely discounted and not present on their budget and the New York State OTDA allows us to do that for a twelve month period for an individual who is single and if we're talking about a family case where there's a child under the age of eighteen, there is no time limit. So that's a huge benefit.

When I'm educating clients about also going back to work, I also want to mention about social security disability. As employed individuals, we're all paying into social security. It's very important that somebody who was physically able to and has the skills to get back to work understand that part of, part of becoming an employee and a working individual and

all that entails, the benefits are that you're paying into a system which can then return your money to you an increase in social security.

And social security disability, of course, will travel with you from state to state.

We also have the thirty percent rent cap which was passed in 2014 where as individuals are not required to pay more than thirty percent of their income, regardless of their income, towards their rent share and that's huge. So many times clients prior to the implementation of this new law, you know, there might not be an incentive. Yes, we had the earned income disregard, but then still a large chunk of that budgeted income that we have to put on their budget would have to go towards rent. Now that's capped at thirty percent and that's huge.

So it's a whole series of things that we try to educate our HASA clients that's out there and we also have a demonstration project called the rise program. I don't know if anyone has heard of that. That's under gay men's health crisis and they work with individuals who are HASA clients currently and we partner with them to get clients into the workforce, to get them the skills

necessary to enter the workforce through computer skills, interviewing skills, job training.

And we also have an internal vocational rehabilitation unit which we've had for many years at HASA.

MS. BARRETT: Thank you. But you know, I'm coming -- I'm going directly to you, Cathy, but for some individuals who are HIV positive and they have all the challenges, but may not be eligible for HASA. What, what do we do? What do they do then or what services are be available for them for income and needing to go back to work? Where's the gap? And how can legally that we can prevent these gaps that they can still get their income, some of their benefits and still work?

MS. BOWMAN: There's a huge gap. So -- and I think what David was saying is at the beginning, was this really reiterates the need for HASA for all. That everyone who's positive needs to be getting HASA benefits because there is a huge gap now between people who have ever been symptomatic with their HIV and people who have not and so for the people who have not, you're not eligible for HASA, so essentially you're eligible for regular public assistance and that's it.

And the only --

MS. BARRETT: Doesn't really pay for much.

MS. BOWMAN: It doesn't pay for much. As people might know, the rent for a single person on public assistance is two hundred and fifteen dollars a month, so you know all those --

MS. BARRETT: And I can get a shoe box.

MS. BOWMAN: Maybe. I don't know.

MS. BARRETT: Maybe not.

MS. BOWMAN: Maybe you can't get a shoe box. So it is two hundred and fifteen dollars a month. That is, I really don't know how many times you can think about that.

So for that population, there's only a ninety dollar work income disregard and that's it. The only people who get the fifty percent disregard on regular public assistance are people with minor children in the household.

So essentially, it's a ninety dollar difference a month for people. So there's no real incentive for people on public assistance to be working except that you actually really cannot live on public assistance. I mean there's that negative incentive, but there's no positive

incentive.

And the other thing that's hard is all of the different benefit systems have earned income very differently and it's really complicated, so HASA treats all of your earned income one way. SSI treats it a completely different way and social security disability treats it yet another way and a lot of people are getting all three of those benefits.

You know, it can make your head hurt thinking about it and I think it is complicated even for providers to understand all those issues and I think trying to then educate all the people who are living on those benefits about how it works is very difficult and I think a lot of people are afraid to go back to work. I think a lot of people, you know, I hear a fair bit like I don't really have enough money to live on. Things have definitely improved since the thirty percent cap on people's income going towards rent has happened. That was a huge shift for people, so that was fantastic, but people are afraid to go back because you know, they're getting their disability and they're really anxious about the impact that working will have on that and it is

complicated and I mean, I won't even get into the rules because you would just -- everyone would fall asleep.

But it's -- they're very complicated and they have lifetime caps on them and all sorts of things and so I think one thing we need is for all of us to be educated about those rules and how they work, but maybe in the bigger picture thinking about whether or not those rules really all make sense, how they're structured. And maybe they need to be simplified in the way that we're discouraging people from going back to work who has all different kinds of disabilities.

Because we also see a lot of folks who aren't HASA eligible, but are getting disability benefits because they have another kind of disability. So all those people also. It's just incredibly discouraging. I think we've created a discouraging system for people and we need to rethink that in the big picture.

MS. BARRETT: Mark, I want you to follow up on the question because I know that you do a lot of work around this, around this issue.

MR. MISROK: And it's tremendously complicated. The complexity of it for many people

has been, is explanation enough for why they have not worked in years and are not planning to because it's so -- you know, there are some people who simply miss out on the possibility of moving to work for months and years on end and there are other people who say, you know what, I just have to -- I can't understand what's going to happen. I'm just going to take a risk and go and are unable to make well-informed decisions and plans for a transition that might better take care of themselves and their own economic stability.

I want to encourage, in terms of needs assessment in this area, because it is so difficult to just go online and find information. Service providers can't do this. People living with HIV or other disabilities.

In other states, there's a set of states that have invested in a project called Disability Benefits 101 dot org. DB101.org. If you go to DB101.org, you will see especially in the California state site of this project, you will see an extraordinarily comprehensive and assessable access to information about the entire, virtually the entire range of benefits that are available to both health, financial related to all

-- including HIV benefits. And in addition, they have an online calculator so that you can actually plug in what the benefits an individual receives and the amount and take a look at various scenarios of what will happen and what will or won't change based on changes related to work.

MS. BARRETT: Okay.

MR. MISROK: So this is one thing we need.

MS. BARRETT: All right.

MR. MISROK: Is to make the information accessible.

MS. BARRETT: So, it's a lot of information and one of the things that you guys touch on and I just wanted to ask Aron really quickly. When we talk about discrimination, and I'm going to ask you to do this really quickly because I really want to give our community a chance to ask questions since it's really such a good topic that we're talking about.

When we talk about discrimination of people going back into the workforce, they really want to work and their benefits area going to be interrupted and they have other things that's going on and they're back to where how can they

handle or what do they do to if they're being discriminated against when they are going back to work? Or they are at work and they are employed.

MR. COBBS: So hopefully they're calling Lambda Legal when they're being discriminated against and hopefully if we're not able to represent them in any sort of impact litigation case, we're at least able to refer them to other resource referrals.

But are you -- is the question, what are people actually doing who are encountering this discrimination?

MS. BARRETT: Yes. What can they do? Uh-huh.

MR. COBBS: What can they do? Yes. Call, call Lambda Legal. Access, I would probably defer to a number of my esteemed panelists here in terms of accessing resources and, you know, reentry programs to secure more traditional forms of work.

But yes, definitely report those incidents. There's a number of laws and protections that exist, but when it comes to an actual robust reenforcement or enforcement of those laws, they're just -- it's not enough. You

know, if you want to be able to access family medical leave, that requires disclosure.

MS. BARRETT: Right.

MR. COBBS: And disclosure is a very difficult thing to do with the stigma that still, you know, is very pervasive throughout this country, let alone in New York City even still.

So it's one thing when we tell people, these are your rights, but you know, closing that gab between legal and lived reality is very difficult because of the stigma.

MS. BARRETT: Cathy, can you just really quickly, just sum that up?

MS. BOWMAN: Well, I would, I would just really encourage people. Lambda does do a lot of big litigation, but to see a lawyer if you're having discrimination issues no matter what, to talk to someone.

And they're also a lot of things that people can do pro se on their own, so you know, the AAOC handles discrimination that violates any of the federal laws, but in New York State, the Division of Human Rights handles things that violate state law and the New York City Commission on human rights handles things that violate the

New York City human rights laws. And you can go file by yourself in those places. You don't have to have a lawyer to do that.

I really encourage people to talk to lawyers. I think we do a better job when we help you file, but if you can't get to us, if that access is a problem, I would really be sending people directly there because in addition to people complaining about their own issues, it starts to gather data for people about what kind of problems that they're seeing.

For example, right now, you know people in the New York City Human Rights Commission are seeing a lot of complaints about how transgender people are treated in shelters. And you know, for them to be gathering that data is extremely important because other people are saying, Well, I'm not hearing it. I'm not seeing it. Where, you know, what are we talking about?' And so if people are actually really going and making those complaints.

And look, two years ago, I wouldn't have told you to do this because the Commission was terrible and did nothing for anybody, but they're really trying to improve the commission right now.

They've hired a lot of new people and with the new administration. It's like a lot of things. There's new administration. People are really trying to put some effort into this.

And hopefully it is no longer a waste of our time to be filing things at the commission. We're starting to really do it a lot and I really encourage people to tell. People who are experiencing these problems, if you can't get a lawyer to help you for free or you know, if you really need to go out there and do it, go do it yourself. You know, people are very capable of explaining their own experience and now that they have better people working there, I think they're able to record that experience.

MS. BARRETT: Thank you.

MS. BOWMAN: So it should be reported.

MS. BARRETT: Thank you. Carrie, I know you have a question, a statement. I'm going to give you [indecipherable] --

MS. DAVIS: So the Commission of Human Rights as Cathy mentioned is under new ownership. Let's put it that way. They have an amazing new commissioner, Commissioner Malalis, and they have a tremendous focus right now on transgender

issues.

They're rolling out a whole training curriculum that's going to go out to all city agencies. They are working with community members to deliver that curriculum. It's all hush/hush, I'm not going to formally announce that.

But I would also say they also have trans staff there. So that when it comes to transgender issues, the Commission rolled out guidelines in 2004. They reissued revised guidelines this year and they're moving forward in many different ways, so I think that's a tremendous opportunity that we have right now.

MS. BARRETT: Okay. Thank you. So now I want to open up to questions from our audience and I'm sure you guys have a lot of questions, so if I could get everyone with our mic to come around. Yeah?

MR. BOLTER: Hi. Thank you. My name is Paul Bolter with the American Liver Foundation and when you talk about discrimination in employment, there's -- especially returning back to work, there's often perceived discrimination and flat out discrimination.

So if somebody is returning back to the

workforce after five, ten, fifteen years either due to their HIV status, housing, whatever prevented them from going, returning to work, that has to be an identifiable reason, an acceptable reason for not getting the job. It's not necessarily discriminatory. It is if you don't have skills, but also there's -- so that might be like a perceived discrimination.

But what are the actual examples of discrimination? I think a lot of people think oh it's because I have the virus. But what about it? You mentioned FMLA, but FMLA is to protect you from losing your job due to your health. So what is the actual discrimination? I'm not sure that was very clear. Like what are some examples of the discrimination people are faced?

MS. BOWMAN: During the hiring process do you mean?

MR. BOLTER: Sure. [Indecipherable] me trying to work. Why -- what is the actual discriminatory event [indecipherable] get the job?

MS. BOWMAN: Well, I mean I, I think part of the point here is that when you have a big gap in employment that people can say I just don't want to hire you because you have a big gap in

employment. And that's why employment services and all that can be very important.

Some of this isn't very subtle. I mean, you know, especially when anyone who is gender non-conforming is interviewing for jobs, they get questions like you know, what are you? You know, what's your name really? Who are you? You know, it's sort of the last frontier where people have no boundaries whatsoever in terms of what they'll ask, you know, down to like what bathroom are you going to use, all of those sorts of things.

So, and you know, a lot of times people -- sometimes these things are hard to prove. People meet people. They interview them and then you know, you just don't get the job. You know, sometimes it's hard to prove.

But sometimes, they're incredibly blatant things. We see particularly horrible treatment when people are actually transitioning at work. Some very intense time that people who already have jobs experience a lot of violence and really, you know, I just met with someone last week who was describing not being able to use either bathroom and having to go to the bathroom in a bucket where he was working.

So, it's not subtle. So that, and with HIV, I think a lot of times, it's like people smell that people are sick. Like you know, what's going on with you? And, and they're trying to figure out, you know, why have you been out of the workplace. And it's actually not legal to ask people why they've been out of the workplace, but people do ask people why they've been out of the workplace. So there are a lot of things like that.

So there are very subtle ways to discriminate against people and some people are very expert at it and it's very hard to prove. And you know, some people are not even bothering. I mean, people thing they have a right to do all of this stuff. I mean we certainly see that in housing, the people are like, You can't tell me who I can live in my housing.' And we're like, As a matter-of-fact, we can tell you.'

You know, but so I think -- you know, and sometimes employers have that same attitude like you can't tell me that I have to, you know, treat this person like I treat everybody else and the truth is yes we can tell them that.

So it's a whole range, but.

MS. BARRETT: Let's take another question for the other panelists.

MALE: Hi. Good morning everyone. Thank you for talking a little bit about the issues that trans populations are facing.

In the work that I do, we have a coming home program at Mount Sinai for those patients who are coming out of prison or may have had some criminal background history.

If you could talk a little bit about what services are for people who have been out of the workforce particularly because of their involvement with the criminal justice system. I think that's a whole other ball game.

MS. BARRETT: Anybody want to take that question? What about [indecipherable]? Mark.

MR. MISROK: That -- excuse me, we have a response over here.

MS. WELLBE: [Indecipherable].

MR. MISROK: Sure.

MS. WELLBE: Okay. Great. Hi. I'm Monica Wellbe. I'm an attorney with the Legal Action Center. I do think when you're facing multiple issues, whether you have HIV and other issues that you might be dealing with, criminal

justice involvement is, is really daunting when you're going back into the workforce. We work with people with criminal histories on reentry issues and discrimination issues and sort of having a good understanding of what your conviction history is prior to entering the workforce is the best thing that anybody can do.

So getting an official rap sheet is a good starting point because a lot of employers are now doing commercial background checks on folks, even though the fair chance act did pass, it usually ends up later on in the process after a conditional offer in New York City now under the law, but still commercial background checks I think about ninety percent of employers are conducting them.

So for people to be empowered to understand their criminal conviction history is really, really important.

I don't know if that answers your question.

MR. MISROK: We've got two over here.

MALE: I have a question. I think it is very important that when someone seeks services that the face they meet in the organizations, the

helping organizations be a face that is someone that they can be comfortable with.

When this whole thing started, the response to Aids in the eighties came from the affected communities and when that response, when those initiatives became community based organizations, the staff in the organization looked very much like the affected populations. In my own organization, we always had formerly incarcerated, formerly addicted transgender individuals working in the community based organization.

And then the blessing happened. In 1997 when the new drugs came through and the treatment and the response became more medicalized [sic] and that as it became more medicalized [sic], the people who were now providing the services were not so much the people from the community, but people from the medical establishment.

And now when we have prep and pep and my question is to you, Carrie, is that we seem to have some kind of -- it seems to me, that we're going to end Aids through pep and prep and I'm a little skeptical about that because while we're trying to get everybody onto pep or prep, there

are other activities that in our programs that we were helping people with. Activities that build self management skills. Activities that build self esteem. And it seems to me, we're emphasizing less on these, this kind of skill building while we think we've got a technological and pharmaceutical cure for this epidemic. And Carrie, I think you touched on it and I would like to know if you have more thoughts on this.

Is the direction we're going in medicalizing [sic] the treatment, are we losing something?

MS. DAVIS: So we've all seen the continuum of care, right? The HIV continuum of care. How do we -- if we look at that continuum, between each pillar, there's a gap and then it steps down. How do we address the gap? It's the gap where the solutions are or need to be found.

So why would a young, a transgender woman of color who's an undocumented immigrant why would she not -- who's doing sex work, why would she not have an HIV test? That's the first thing, right? Because we need to identify.

The solution is to moving her if she's positive and this is an actual person that we work

with, moving her to a point where she's in care and she's undetectable, requires more than medical solutions. So it's the gaps where we have the solution to the continuum of care. It's the same with hepatitis C.

So the solutions, when you make a map of that and I do an exercise where I just, I put up a power point and I ask people to fill out what the solutions are to each individual case, we realize that they're not about giving people medication. That's part of it. But it's about everything in between. It's about language issues. It's about immigration issues. It's about legal issues. It's about self efficacy, believing that you can do something. That's not something you can give a pill to somebody for.

So if you want, if someone wants -- if you can get someone to believe they can do something, you've taken a huge step towards accomplishing your goal. These things require more holistic interventions that we have moved away from since the 1990's.

So the solution is to see our, that HIV should be in our Department of Labor budget. HIV should be in our Department of Education budget.

And so forth.

DAVID: Hi, it's David. David, this is for you, David and it pertains to I'm going back to work having been a HASA client. A lot of the clients that I've been speaking with are fearful of going back to work because they don't have the information readily available to determine what the impact it would have on them.

Is that information readily available without actually having to go to disclose to your case worker?

And you mentioned something about the ninety dollar disregard and then the fifty percent off the rest over a twelve month period. Is that -- because sometimes people don't work every month or have a regular job, so it's work here, a month here and maybe not at all. So how is that calculated? Thank you.

MR. PIERSANTE: Okay. So thank you for the question.

So to answer the first part. Our budgeting, as Cathy can attest to, is a little bit on the complicated side and so we do not want to rely on our twelve hundred line staff, well we're twelve hundred in total, vast majority of line

staff, to tell a client this is exactly what your budget is going to be. So we have a specialized unit of which I'm in charge of. That's one of my areas that I oversee, where we do just that.

So as I mentioned before, we have that demonstration project with the gay man's health crisis. So a lot of times, they'll, you know, one of the staff there will shoot me an email and say, "David, this is an individual. He may want, you know, he's been offered this job, twenty thousand a year. Give me a snapshot of what his benefits are going to be." And then I can do that.

I would much rather do that and keep it within me and my staff than have the information disseminated amongst so many people because it is a complicated process.

So that's the first part. The second part regarding sporadic employment. We are able to apply the rules of the income disregard both for part-time and for full-time employment. And at any point in time when one's income changes, especially if there is a decrease, we need to know that because then that -- you know, that individual's budget is going to have to be changed to reflect a lower income amount and if somebody

works periodically like for example we have some individuals who teach and then they have the summers off. So during that summer months, of course, we're going to remove that income and then apply it back.

And that twelve months need not to be consecutive, so if you are in -- let's say you have a job for six months. You lose that job. Three months later, you get another job. If you're a single individual, you still -- you have not exhausted your twelve months of that benefit, so we would turn that back on for you.

MALE: Okay. Another one.

MALE: Can I just follow up? A quick follow up. Folks may or may not know that for anyone who is getting SSI or SSDI that the social security administration has posted, published and posted online what's called the red book which has all of the rules and regulations that you can take a look at and understand to assess what would or would not change in terms of beginning to make work earnings and change to your income.

So social security does allow us as adults to have access to that information and make the policies transparent. So both beneficiaries

and service providers and policy makers can see that and understand that. And I do think we need to encourage our friends at HRA to empower us to also as adults have access to the policies being transparent so that we can actually take a look at them. We can go online and see them and have the empowerment to understand and make decisions and be equipped to make well informed choices about work and work earnings.

FEMALE: Yes. Good afternoon. The more that I'm listening to the panelists and the voices in the room, the more it's becoming clear to me that this really has to be a broader and ongoing conversation because we're dealing with changing some policies and adding some things maybe legislatively.

If you're going back to work, you're probably going to have a better chance of working in an area that is supportive of serving of your HIV or your disability.

I'm returning back to work twelve hours a week and I'm struggling. And I'm struggling because I got health issues. I'm struggling because the sticker shock of SSI, DSS. I'm from Tri County. DSS is Department of Social Services.

I nicknamed them Department of Satan Services, but the issue I'm bringing up is that they're all going to deal with you differently financially and if you're not prepared for the sticker shock of your rent going up, food stamps going down, now I got to add in transportation money and all of these other issues that will come up, I would really like to see a discussion and a development in the agencies that serve and otherwise of employment support system. A peer support system within agencies. An employment support system because you might be ready to go back to work and three months later you get a health issue and now you're out.

DSS oftentimes will sanction you because you got sick and they didn't think it was enough reason for you to leave a job. You voluntarily left a job, now I'm going to sanction you for three months.

We need to have a broader conversation and maybe start a bank where information can go in related to different employment challenges and issues.

So I'm hoping that that might be something that can be helpful in addressing the

larger conversation. Thank you.

MALE: I have another one here.

MS. BARRETT: We have time for one more question because we need to stick to the time. This is a really a big hot topic. I can only take one more question so that we stay on track. You can speak to the panelist if you have questions afterwards. Go ahead.

MALE: So I'm one of those persons who is transitioning to job after ten years of not working. And because this is about, you know, the experience, so recently I had my -- I get hassled and I went to re-certification and I been speaking with my case manager. So both of them have different answers to my transition questions, so I find that, you know, as a consumer, it is difficult to get a balanced answer as to how do you transition.

HASA had two meetings and they both had different answers. So one of the things that one experiences -- the one on one builds confidence, but if the other person who you are asking for information doesn't have a clear sense of what, you know, what you need, you feel lost. So then it becomes a moment of fear, so am I ready to do

this? You may feel it, but again we're talking about support.

It's, I think a lot of the focus should be, at least from my experience, in how to do support the individual who is transitioning, who wants to go back to the workforce. Not that they are not available resources out there. I mean, we have here a list of places we could go. But it's the relationship that empowers you to say yes, this is possible.

And the challenges, and I've heard also other people who are in the same transitioning mode, is that everywhere you go and ask the question to perhaps lead you to that transition, everyone has -- they don't seem confidence in letting you know how to do this or how to build your own confidence to do this. As I said, you know, I went to HASA and two different answers and then you go okay, so perhaps this is not the way to go in transition. HASA has no answers for me today.

So then you regress. So, I think those are the things that need to be looked at because it's a personal experience. How you go in transition.

There's the case, especially for transgender. The fact that it's a world where degrees are important. Where the more education you have with a little paper may give you, open doors for you regardless of whether you are gay or transgender, but a nice piece of paper.

And so we have [Indecipherable] like you know, you do volunteer work, they certify you for this, yet the feeling is that is that enough to put a good picture of me when I am interviewed? What other background things I have to do to ensure that I'm at my optimum at that interview process. Not because I'm gay, not because I'm transgender. It's am I qualified because our society runs on okay, you work for so long, or oh you have all these degrees or you have all this experience, but how do you feel confident in those things.

To teach those who are in transition to feel confident about those, whether if you volunteer. Great. But how do you feel confident about that volunteer work to go and confront an interview and say, listen I have that experience. You know, it becomes numbing to you, the process because you are unsure because there are so many

other criteria needed that sometimes go beyond just being gay or transgender. I mean, I met a lot of transgender girls who have degrees in cosmetology and they want to do it, but it's where do I go to get a loan? Can I get a loan? Am I respectable enough to get a loan?

So it is behavioral on so many levels because it's not that you don't think that you can. It's get out of that fear.

MR. MISROK: Okay. So real quick, I want to address the HASA specific issue.

We're currently working with our new Director of Policies, Procedures and Training to get desk guides, not just for this issue of income disregard, but for all of the actions that we do to really make a one pager for everybody so everybody understands exactly what all of these processes are and they are complicated, unless you do this everyday like I've been doing forever and ever. So that's number one.

Number two, I'd like to give you my information at the end. And then I'm going to look into your case on my own, if you would like that. Thank you.

MALE: We have time for just one more

question.

MALE: I have just another question. I have a simple statement.

MS. BARRETT: Okay.

MALE: Each individual agency within New York State; HASA, all of them have different, different -- I can't think of the word. It's not coming to my mind. Of what you can do and earn going back to work. They all have different things. And they all seem to keep it under wraps. How do we, as clients, find out what they are? Because as he said, he went to two different HASA workers and they both gave him different answers, os there is no one, one --

MS. BARRETT: There's not one answer to fit. There's not one size to fit everything.

MALE: Everything. So --

MS. BARRETT: Right.

MALE: -- even if you go to a lawyer and say, Can you help me find out what it is I need to know?' They will tell you, I got this answer and I got this answer.' And it's happened to friends of mine that have done it.

MS. BARRETT: Uh-huh.

MALE: I had a friend who went to work

for the summer. He made so much money, they told him they have to cut his budget because he made too much money over the summer and he only worked for the summer. He made, only made too much money within the time that he was working, so they had to cut his budget because he made too much money.

MS. BARRETT: Uh-huh.

MR. MISROK: Okay. Real quick and then I'm going to wrap this up.

MS. BARRETT: Okay. Wait, I'm sorry. I know that we need to answer, but we have another panel and these are very important questions that we need to address, so David, your information will be, we'll give out your information so that we can -- you can address some of the questions and we can email because these are very, very important, but we need to be respectful of the other panel and time.

Panelists, I do thank you. Questions, I'll answer any questions. I do thank you, but we need to wrap this up. Thanks everyone.

So we have a five minute break. Five minute just to go to the bathroom and come back.

MR. LESIEUR: All right, folks. I really want to get this started. If people could

please grab a seat. We have our last panel on housing. Don't make me call people's names out. All right, folks. I know we need to clear this room out by a set time and I have the glory of having to go to Albany later on, so we want to get this show started.

All right, folks. So welcome to the last track. If folks could -- I know I'm talking loud enough, so. We have our last track. We're just going to talk about housing across the entire [Indecipherable] metropolitan area which consists of the five boroughs of New York City, as well as West Chester, Rockland and Putnam and as you're going to learn through this panel, the needs and the life situations between those two -- between the five boroughs and the three counties north of the city are very, very different and their needs are very different.

Before we start with our panel and introduce our panel, I'm going to allow our esteemed presenter here, Pamela -- I'm not even going to try and pronounce your last name.

MS. FARQUHAR: Farquhar.

MR. LESIEUR: Farquhar. Pamela Farquhar who's the Director of Housing in the New York City

Department of Health and Mental Hygiene is going to start us off with a presentation to set our minds right and then I'll start with our panel.

MS. FARQUHAR: Okay. I think we moved into afternoon now. As Matt introduced myself, I am Pam Farquhar. I'm the Director of Housing in the Housing Services Unit at the Department of Health and Mental Hygiene. I'm glad to be here to provide some context and some background to the housing services that we provide based on the two grants that we administer, both Ryan White and [indecipherable] at the Department totaling about over fifty-seven million dollars in housing services for New York City, as well as the tri-county region.

So for 2016, for the Ryan White EMA, there are approximately ten million dollars allocated by the Planning Council for New York City housing services that were spread across three major service categories; short-term housing, supporting housing. Basically providers providing housing services as well as traditional case management services and non-traditional, such as housing readiness workshops, ADL skills assessment and provision of services, in addition

to [indecipherable] and other advocacy referral services regarding case management.

Additionally, we have the service category, housing placement assistance. Our HPA providers work very diligently with brokers, landlords and building management companies to secure housing -- identify and secure housing on behalf of clients. Clients can be placed in congregate or scatter site facilities based on their needs and their services that they are needed for.

Last category, short-term rental assistance. Basically, it's for clients who are not HASA eligible. We heard a lot about that in our previous section, who for the most part, have their housing unit, however they need assistance in paying their monthly rent and so they seek rental assistance from our short-term housing rental assistance provider.

So again, those are the three categories that are funded under Ryan White. Ryan White exclusively supports emergency and transitional housing and I'll talk in the next light about [indecipherable].

In regard to tri-county, Ryan White

funding, in 2016 there are approximately just short of five hundred and seventy thousand dollars allocated for housing services in the tri-county region, specifically for short-term rent, mortgage and utility, however in New York City, there's a little caveat. The mortgage piece is not included. It is rent and utilities that is covered.

As I mentioned, the [indecipherable] EMSA. [Indecipherable] decides to add an S in, so it's eligible metropolitan [Indecipherable] area for [indecipherable]. In 2015, there was a forty-seven million dollar allocation for housing services, the bulk of which was for New York City. Similar categories; supportive housing, housing placement assistance, rental assistance, as well as just straight case management or supportive services that were primarily provided by HASA with regard to straight administrative supportive services. Excuse me.

Tri-county received an allocation of about two point one million dollars for rental assistance and supportive services and in 2014, HUD decided to expand the New York City EMSA to include three counties in New Jersey that we're

responsible for administering. That's Ocean, Middlesex and [indecipherable] and they receive a little over one point three million dollars in funding.

When we talk about housing instability, these are the service -- the inclusions when we talk about individuals who are precariously housed or homeless, so includes, of course, street homelessness, emergency shelter, residing in an SRO could be funded by HASA or not, but occupancy in an SRO or a hotel or motel would certainly include you for being unstably housed, as well as if you were residing in a transitional supportive housing program, anything not permanent housing is considered transitional/emergency or being categorized as homeless as well as living double or tripled up with a friend or family which also consider you to be homeless.

How am I doing Matt? All right, awesome.

So Ryan White housing clients served in 2014. There are approximately one thousand, four hundred and forty-three clients who were served. These are unique clients. All who received at least one service from their respective provider.

And in tri-county, one hundred and fifty-nine clients were served, again using the same barometer.

This is the slide that we want to really, just really hone in on for this presentation and for our discussion this afternoon. In tri-county, Ryan White clients, there are about one thousand two hundred and fifteen clients who were served in 2014 of which one hundred and fifty-nine or thirteen percent who received housing services, which leaves a large percentage of clients who did not receive housing services and of those who did not receive housing services, only eight hundred and forty-two -- or not only, but eighty percent of those, we know their housing status and two hundred and fourteen whose housing status was unknown; either just based on not providing the information in our E-share system that was talked about by Justine this morning and Dr. Irvine.

And of those for known status, eleven percent were unstably housed and seven hundred and forty-eight individuals were stably housed.

But we want to hone in on those who were not -- who were unstably housed for this

presentation and I guess for this discussion when we talk about the needs in tri-county in regard to housing services.

So when we look at the individuals who are unstably housed, they are most likely to be male, under the age of thirty, unemployed, as well as ever been incarcerated.

So I just wanted to -- I'm glad to be able to provide this context for the discussion this afternoon and to really talk about the needs in tri-county and what's it -- in order to hopefully be able to reallocate monies as necessary without hopefully strangling those individuals who are receiving services in New York City.

FEMALE: Thank you.

MR. LESIEUR: Let's take this thing out. My ADD kicks in and I can't stand that still. So I want to start with Barbara and go all the way to Jason and I want you guys to just introduce yourselves and where you're from.

MS. BENTO-FLEMING: Hi there. Barbara Bento-Fleming, Director of Housing Services Lifting Up West Chester. And just to quickly cover, we have both Ryan White and

[indecipherable] contracts in the funds we administer.

MR. ALVAREZ: Yes. My name is Victor Alvarez. I'm a consumer and director of living together, which is an organization by and for people with HIV and Aids and we started in 1993 and we're funded in the Ryan White part A care act.

MS. AHMED: Hi, I'm Danielle Ahmed. I'm the Program Supervisor at Lifting Up West Chester and I oversee the Ryan White part A program housing rental assistance and also the [Indecipherable] case management program.

MS. AIDALA: Hello. I'm Angela Aidala and I'm [indecipherable] Public Health and I'm the Co-PI of Study Director of the Chain Project.

MR. WALKER: Hello. Good afternoon. My name is Jason Walker. I am the Coordinator of the Aids Housing Advocacy Network for Vocal New York. Vocal New York is also formerly known as the New York City Aids Housing Network. Yeah.

MR. LESIEUR: So we have a couple of formal questions that the Department gave me, hints on what I could ask. But I'm going to start with Angela. Since you've been running a chain

study since as long as I can remember and so you guys have been a wealth of information on the intersection of HIV and a lot of other factors. I wonder if you could sort of provide us with a brief overview on what's the relationship between HIV and housing?

MS. AIDALA: Sure. I put together a little quick briefing paper, which is really literally hot off the press and in answer to the question that was particularly interested in looking at some of the differences perhaps between New York City
and tri-county.

And you know, again, just on the first page, we can see you know, and it's no news, but we have lots of data from 1994 over time, several thousands. We've done about nine thousand interviews now, you know, that we do on a regular basis. New York City and the tri-county area for again, approximately yearly, close to eighteen months from now, so that sort of large sample size designed to be a probability sample, meaning that we design it to be representative of people who have had some contact with the service system, but not necessarily in-care social service or we

recruit people from social service or working with providers, such as you all. Recruit folks that may have had some involvement with the care system, but not necessarily in care over time.

But just really quickly. You know, we knew that lack of secure adequate housing is widespread. It's associated with worse outcomes in terms of medical care engagement, in terms of the care cascade and not surprisingly then, worse outcome.

Let me repeat that. Lack of secure, stable, adequate housing is not just literal homelessness and that's one thing that from the beginning of our work, homelessness, if we think about it, is about the most extreme on a continuum of not having adequate, safe, secure housing.

People who are in housing, and this is what we see a lot, particularly in tri-county, who have a place. Who have an appointment, but are severely rent burdened are at risk for housing loss and they are often housing loss. Housing cost go up. In this brochure, I looked up -- I hope I got it right. The kind of fair market rent, you know, whose SSI or SSDI could even cover fair market rent for a studio? Yeah, exactly.

It's twelve forty-five now? Yeah. Exactly. And it's a little bit higher actually in West Chester than it is in New York City. Right? So and we also know that, that there's less rental units, a lower proportion of units. That's probably why it's higher, right? Because the communities in West Chester are not as welcoming to multi unit buildings, so there's a lot of things structurally.

And that's kind of the point that I'm trying to make. That the fact that in the general population as well too, this is becoming more -- there's attention to it now and generally the persons who are housing insecure or energy insecure, are also then skimp on food. You want to think about well, you know, you've got to pay the rent or you buy good and healthy food. Right? It's not just heat. It's heat or eat or be on the street. You know? So as some of our respondents tell us when we do these interviews.

So I think that we can think about, again, we don't have time now, but you know, again there's direct affects. The stress, the exposure, people are transient. They're moving in and out. They're staying. Women especially stay in places

that aren't so necessarily safe. It may not be a virulent, domestic violence situation, but it's still a situation that they stay in that's not necessarily healthy for them and particularly if there's kids because there's such limited options as well.

We have data on this. We have other reports on it. I and a team of about six others, Jenny Schubert [phonetic] and other academics, the big review of the literature, a hundred and fifty-two studies that show this as well too from 1996 as well as chain.

Unstable housing as well as homelessness associated with worse connection to care, delayed entry into care, dropping out of care, lack of adherent ART use, lack of using ART, ART at all. Right? Not using ART and again we'll kind of think about why that might be. Housing costs are out of reach.

Receipt of housing assistance then is associated with improved -- persons who have changed, who improve, who get housing, who get their housing needs met show better outcomes.

Just really quickly here, if you'll look at on the next page of this, the persons in tri-

county are more likely to be doubled up. They're more likely to be doubled up. Less likely to be literally homeless, street homeless, more likely to be doubled up. Some in transitional housing.

A few words about doubled up. Doubled up now means maybe good because that means you have a social network or at least some place where you can go to maybe be in a regular home. But it also can be associated with worse outcomes. If that family member, if you haven't disclosed your HIV, you know, it's associated often with falling out of care itself because you don't want phone calls coming to that address. You don't want your meds in the refrigerator and so you, you know. And also in some instances, you're not -- maybe you're staying in some place that's not so friendly and supportive. You can't use the kitchen, right? You cannot use the kitchen.

If you're in a -- the other thing about it is you're not under the purview of any service provider, so if you're in some kind of -- even in the shelter, homeless shelter. I'm not recommending homeless shelter, but if you're in a homeless shelter, there's meals and if you're having some kind of freak out or some serious

health issue, it comes to the attention of folks that are there, particularly transitional housing as well too.

So the fact that there are people are more often in, in doubled up, you know, it's still associated with worse outcomes compared to again, stable, secure, you know, and adequate housing.

Housing programs are an addition to. It's not just the little housing, but people who have, you know, are facing eviction. There's a stress dynamic for those as well too, of course. Who are in really poor quality. We have people who are living with HIV, who don't have regular heat, who have mold and other kinds of you know, vermin in their places because there are places that they have with few resources to go otherwise.

What else can I say? This, this chart on the back. We, we put together a classification of housing need looking at persons who had their own place, had a lease, but were severely -- more than fifty percent of their income from all sources, you know, went to rent. Severely rental burden. They needed rent assistance.

Those that needed placement, permanent housing. In other words, they didn't have their

own place. They were in temporary, transitional, doubled up or street homeless, so they needed both rent, right? But they also needed a place. And then people who needed permanent supportive housing.

And again, this just shows you the relationship between some indicators. The first one is emergency room use, which is an indicator of poor engagement with care, suppressed viral load, good physical functioning and health quality of life.

If you look at the persons. The darker color are persons who need permanent supportive housing, but again comparing rental assistance. So they're not unstable. They haven't moved around a lot. They have a place. They have a roof over their head, but they're at risk of losing that and the day to day [indecipherable] outcomes.

And again, there are a lot of other ones discussed in the text. I have to quit now, I think? Yes. Okay.

MR. LESIEUR: Well, I'd like to give the other panelists some time to talk too. As always, researchers love to show off all their data.

MS. AIDALA: Oh I know, I know, I know. I know, I know. What can I say? One last thing, okay?

We did an estimate based on those categories. We did an estimate because I was asked to do an estimate and this is just an estimate on our data. We estimate that there are about a thousand persons in the tri-county area living with HIV and Aids who need rental assistance, but not getting any at this point in time. And three hundred and seventy-six that need housing -- placement, permanent housing. Meaning that they need, you know, they're homeless, literally homeless, doubled up or whatever, but they don't have their own place, that they need housing, as well of course supportive housing -- I mean rental assistance to support that.

Okay. I quit.

MR. LESIEUR: Angela, take a deep breath. Thank you. That's a lot of data.

So I want to switch from, we just heard a lot, a lot of data, very valuable data and I want to switch to Victor. You described yourself as a consumer. I know that at least on more than one occasion, we've gone to New York to Washington

D.C. and you've told the consumer's perspective on what's going on in the tri-county. So I want to give this audience a sense of what happens to that consumer who's losing their housing or who's unstably housed. What happens to them?

MR. ALVAREZ: It becomes very difficult. I mean, she said it very well earlier. It's not just about taking meds and seeing your doctor. It's about a stable home. If you don't have a stable home, then probably your nutrition isn't stable. You're not getting enough food. You're not getting proper food. So it just goes on and on and on and it escalates.

Now my job is, you know, I work very closely with Barbara. She's always been there. She's a sweetheart, but my job is to teach people while you're going through those transitions to still try to take your meds. Still try to keep up with your doctor because the last thing that you want is to get a nice apartment to find out you end up in the hospital. Okay? So it's how do you do that and that's my job and that's what I do. I'm like the goal keeper. When they come out of play, I kick them back into play. You know?

But it's very difficult because you

know, we talk about affordable housing. Affordable for who in West Chester County? I pay seventeen hundred dollars a month for a two bedroom apartment. But listen to this, I paid thirty dollars a month for water. We live on a planet that's three quarters water and I'm paying for water and it's not even drinkable. So you know what I mean, so you know.

When you look at that and you look at the rents and you look at we have people in a furnished room who can't have visitors, can't have anything to cook or anything, paying six, seven hundred dollars for a little bitty rooms where I've seen prison cells that are bigger. You know, and then you expect people not to become disenchanted and not, you know, and not to fall out of care. When you figure if no one else cares about me, the hell with it. And that's what happens. That's the reality.

You know, I don't like to deal with statistics and percentages. Those are numbers. I deal with people. With human beings. You know, where are you at right now and what are you going through right now and how can we help you and what can we get.

And we talk about ending the epidemic in 2020. I don't see how you're going to do that if you keep cutting funding. It just doesn't make sense to me. It makes absolutely no sense. You know? We just found out that [indecipherable] may be cut. You know, we lost another housing program because of the new guidelines for the new RFP that went out. The agency that was doing it can no longer do it, so what are we going to do?

MR. LESIEUR: Parver [phonetic] or Danielle. You're both in the same agency, so I'm trying to get a sense of what your service -- who does what in the agency, but can you just tell -- the client walks in your door and they're saying they're about to wind up on the street. What options do they have?

MS. AHMED: Well, I mean I think that it's kind of been covered, but just to reiterate, we'd want to take a look at what their income is. It is true that most people in tri-county are unstably housed.

There's not a lot of street homelessness. I think, I think there are many reasons for that, but I think the primary reason being that tri-county is largely residential.

It's a lot of private homes. That doesn't really lend itself to street homelessness. And even when you have these city based buildings, the tenants themselves are not really receptive to the idea of street homelessness.

I think that tri-county does do a pretty good job of trying to get people off the street and into a shelter, so if the person is in the shelter, in a sense they actually may be better off.

We do have a couple of buildings that were housing projects that were specifically developed to address street level HIV homelessness, so that you could actually go into the shelter, be assessed if you disclose. If you don't disclose, then you get a regular -- what was it, Department of Satanic Services? You get a regular -- and I think it's Department of Satanists or a Sadist because it's quite painful even as, even as a staff person.

But if you do disclose, then you can be placed in housing and it becomes permanent housing if you choose that housing. They're basically studio buildings and it's two different locations. One building has a lot more supportive services

and food and the other one has less supportive services. Although they both have really nice, shiny floors because I've rented them. That's just an aside. Hohman [phonetic] Garden fan, here, so.

But I think that it's harder for you if you don't disclose. If you don't disclose, then you can't be placed in these projects and then you become unstable. So we would take a look at the person's budget and see what they can afford through our rental assistance program. For our West Chester program, we can give up to five hundred and fifty dollars per month for rent. It's short term housing assistance that was originally designed to be there for six months and --

MALE: Five hundred and fifty and what's the average rent cost up there?

MS. AHMED: I mean, it's -- it depends. Honestly, it depends on what city you're in, whether you are a southern or a northern resident of that city, but just as she was saying, the one bedroom, the fair market rent levels are now twelve forty-five for a one bedroom in West Chester, which may cover an apartment in Mount

Vernon, but certainly not in Dobbs Ferry.

So and then there's some places that, you know, that wouldn't -- there's also a law, just in case you don't know that just because you have a housing subsidy like [indecipherable] or section eight, a law was actually passed in New York State that does not, does not mandate landlords to take your subsidy. So even if you can afford the rent with the subsidy, the landlord can say, We don't take any subsidies. We don't take [indecipherable]. We don't take section eight. We don't take DSS.' And either the person can pay or we're not renting to them and apparently that's very legal.

So you know, we can find housing sometimes and still not be able to secure the unit. But in general, we'd have to take a look at what they're looking at. We like to direct people towards studios and I have to say there are some people that will say to me, Well, why should I live in a studio or even a one bedroom in Yonkers if I can live with my mother in White Plains?' There are some town preferences in tri-county. Even lower West Chester, but certainly middle and upper West Chester, let alone Rockland and Putnam.

They are not really accessible by public transportation at all.

So if your family all lives in Greenburgh, we may be able to house you in Yonkers, but people will say, No. My mother is eighty and how am I going to get to Greenburgh.' Or you know, where is your doctor becomes the other factor. Can you get housing in the place where your doctor is located?

So each case is different and not everyone who's unstably housed feels that they're unstably housed. You know, if you are actually in your parents home and it's very spacious and there are some older home owners who have maybe children in my generation, but their parents have houses and they're like I'd rather stay and help my mom and be in this house.

FEMALE: And I wanted to add that to clarify those facilities Danielle was speaking of, unfortunately are for singles.

MS. AHMED: Right.

FEMALE: So that's only for a single individual coming in, willing to disclose and say they're homeless and accept Yonkers.

MS. AHMED: Uh-huh.

FEMALE: And a building that's "identifiable" so we clearly get those calls where the resource that are out there aren't acceptable and a person absolutely has a right to choose where they live.

MR. LESIEUR: Do we have any sense of what's the need in the tri-county area for Ryan White or for housing services people with HIV?

FEMALE: Well, it's difficult because again, with our Ryan White, it's a supplement.

MS. AHMED: Right.

FEMALE: So as you were saying, the average one bedroom rent, we are a [indecipherable] provider, still above thirteen hundred dollars, so the five fifty may not even get you where you need to be. There's certainly a cap on the number of [indecipherable] slots. There are eight years section eight waiting list, so in terms of the need, it's hundreds of people that as Danielle said, may not identify as unstably housed, but they're not in their permanent situation.

And we do have, as Danielle and Lisa was talking about, people don't even talk about it because it's so dysfunctional. It's a

dysfunctional version of HASA. There is something called the enhanced shelter allowance in West Chester. First of all, even if you disclose to social services, the workers don't know about it. You do have to be at that threshold in terms of your health being in decline and we've actually had situations in that program if you stabilize and got healthy, they took it away.

And again, when we're talking about rent levels, I heard two fifteen, I think, for -- it's two seventy-one in West Chester and if you are eligible for the rent enhancement, then you get four hundred and eighty dollars to find an apartment with. Which, as Victor said, the rooms are six hundred and above.

So, I mean we did some canvassing of some of the providers just to get a sense in terms of who they're seeing, who may report that they're unstably housed, but that's really we found, you know, a clear -- the clearest way to find out who they are. If they're not coming through that door and particularly in West Chester, you have to disclose and come through a service provider door before you can even figure out what services are.

Where like in the New York City system,

you're aware that there are services around you. So that's one of the problems too, so typically our network is very important because if they show up with Victor, he can say have you been here and we'll be sending consumers for support with living together.

FEMALE: I just want to say like one thing in terms of housing subsidies. Because of federal reductions, we've lost money for the [indecipherable] grant and also because section eight has been almost continuously frozen for like a decade. There's no movement. When I started, which was eleven years ago, there was movement. You might be in Ryan White for one year, six months, three years, and then you would either be able to go into [Indecipherable] because a spot was available, or a lot of our folks went into section eight. You know and that was continuous movement.

Since section eight closed, that, you know, they, they were actually a private organization took over the county section eight and they're no longer accepting new applications. So if you didn't put your application in four years ago, you cannot apply at this time.

Now people will periodically get into section eight. It opens up for like two months and it's like lotto. Oh, I won a section eight voucher. And then again comes the mad dash to find someone, a landlord, that will take your voucher at that rent level.

Just to let you know the other thing that happened is that the fair market rent levels are actually from when, Mark? 2010 or are they the levels that they're going by now?

MR. MISROK: Well, no. They just changed. Our problem is they've gone up and then they've come down again.

FEMALE: Right.

MR. MISROK: So even folks that we've stabilized and this is what we're seeing in our [indecipherable] program, you've been stable five or six years. Your landlord is entitled to a legal rent increase.

Well, the fair market rent in 2010 was thirteen hundred and ninety-four dollars and as of 2016, it's twelve hundred and forty-five dollars. So, even if your landlord is not lowering the rent --

MR. LESIEUR: Make sure your microphone

is to your mouth so we can hear.

MR. MISROK: Oh, I'm sorry.

MR. LESIEUR: Yeah. And I just we -- I also want to give Jason a chance too to talk. So we have a very friendly congress, not really. We haven't seen an increase in section eight vouchers, was it the last president? I'm not certain. There's not going to be an increase in Ryan White funds coming out for the foreseeable future. You know, [indecipherable] sometimes we get a dollar here and there increase, but it doesn't come to the city.

So what is being done to kind of close the gap? What can advocates do? What is Vocal doing? What are we doing to try to address some of these unmet needs, being aware that the federal government is going to be AWOL in this process?

MR. WALKER: So we're really looking to lean on and very strongly on the governor this year. Particularly around really honing him and make sure he owns up to his plan to end the Aids epidemic in New York City by 2020, right?

World Aids day, the Governor came out and made this huge announcement in front of thousands of people saying that he had two hundred

million dollars that he was going to put into his budget this year. We looked at the budget and didn't see any of that money. We were expecting that this money would do one of two very important things when it comes to housing. One, expanding housing services to include asymptomatic folks living with HIV.

Mayor de Blasio put up his portion of the dollars and we see that in the budget, but we do not see anything in the governor's budget.

The second thing that we expected the two hundred million dollars to do is also to create housing, similar programs as HASA, but really specifically just focusing on providing enhanced rental assistance for folks throughout the state. Right. And some of these, like the [indecipherable] county area, Buffalo, Syracuse, Rochester.

So the Governor is upset with Vocal because we really came out hard on him. Like yesterday in Politico, but we're going up there on March the 9th for our annual HIV/Aids [indecipherable]. There's flyers up front.

But as I'm listening more and learning a lot more about what's going on in the tri-state

area, I mean the tri-county area, I think it's very critical and important that the planning counsel and many folks from the tri-county area goes up there and talk about the need.

The governor is challenging to work with sometimes, but I think he does respond to public pressure. So we are implementing and going to be exercising some actions throughout the next month, so we'll definitely keep folks in the planning counsel abreast in the loop.

But I think it is very important that right now, we should just actually like cease this opportunity and really lean on the state and really lean on our local governments and really step up, especially if we are looking at cuts coming from [indecipherable]. I'm not too quite sure if it's going to pass the senate right now, but who knows what things may look like in the next upcoming years.

But that's essentially what we're doing. We're trying to hold our political officials to the fire and really just make sure that we get the people, particularly people living with HIV/Aids for service advisers, folks who are often [indecipherable] HIV to really join up with us in

solidarity to make sure that we get the governor to put this two hundred million dollars in his budget this financial year.

FEMALE: And I think that's so very important because that is the only reason these services are here now and I've been doing this a long time. Dating myself, but we're made progress and then it rolls back. Because I can remember going to Washington D.C. and we all had tee shirts that said, Housing is an AIDS issue.' That was like, I don't know, 1995 or something. So here we go. It gets better and maybe we get complacent and your voice is so important because we have to just, you know, bring it back up to the forefront again.

MR. LESIEUR: Victor, so most of us who live within the five boroughs, we know elected officials and we talk about HIV needs, the response, can I just a little higher for you. And I'm just wondering if you could sort of, without naming names, but what's the kind of receptiveness that you've gotten from elected officials outside of the five boroughs on HIV service needs?

FEMALE: We can absolutely say names. Nina Louise [phonetic] is on the top of the list.

MR. LESIEUR: If you want to name names, follow me.

MR. ALVAREZ: We have a few that have always been very supportive.

FEMALE: Absolutely.

MR. ALVAREZ: Okay. Absolutely. Have always been very supportive. But then, there's that other that are very two faced. They'll tell you one thing when they see you and then completely vote in the opposite direction when it comes time. So, you know, this is part of the game.

And what Barbara was talking about years back, that's when I had hair. We're going back a long ways. Okay. Because in two years, I'll be seventy, so you know, I'm not. You know, with everything considered, everything considered, you know, heart disease, HIV and now I was just told I have diabetes, but no. We really need to be more proactive. Okay.

And she was right. What happened for many years, we were getting increases when I was on the planning counsel. Under Giuliani, we got more money, more money. Some people just got complacent and said oh this is, you know, let's

not rock the boat. But that's changing now. And you know, even we can see there may be a day when there's no more Ryan White with managed care taking in, expanded Medicaid taking over services. And you know Ryan White is the payer of last resort.

And so as you begin to take -- and other agencies begin to pick up the -- what happens to Ryan White? But you know, again what happens to the undocumented? What happens to the people who are not in care? I feel disenfranchised, the transgender. You know, what happens to those people?

MR. LESIEUR: One questions and then we're going ask the audience. So in terms of the sense of people who not eligible for public assistance, the U word, I'll call it. What's the sort of need in the tri-county area for those populations who may have not been born in the United States?

MS. BENTO-FLEMING: Are you speaking about undocumented?

MR. LESIEUR: The U-word.

MS. BENTO-FLEMING: And when we talk about tri-county, that is important question

you're raising Matt because there is clearly a distinction as we all talk about between West Chester, Rockland and Putnam.

MR. LESIEUR: Microphone.

MS. BENTO-FLEMING: Rockland staff has been doing wonderful work in terms of outreach and so many of who they serve are undocumented population, so they can get them in for treatment, but then all the other services, support services are lacking.

MR. ALVAREZ: One of the issues, you have to remember, when you talk about West Chester, Rockland, Putnam, even further up, Duchess, Orange County. You have a big migrant population. They move around. You know, they go to work on different farms to make their money and they move around, so it's very hard to get them, to service them, to get them tested, to get them into care because they're too busy trying to survive.

MR. LESIEUR: Uh-huh.

MR. ALVAREZ: You know, there was something I heard about eighteen years ago at an [indecipherable] conference and it's always stuck with me. There's a woman from Africa who came and

she was speaking and she said, "You people here don't understand, but I'd rather die in ten years of Aids than tomorrow of starvation." And that always stuck with me.

And then you know, that's what she was talking about before. It's about survival. It's not just about taking meds and medication and seeing your doctor. But it's about survival. You know, yeah there's people abuse and use the system, but what I find most of the people are just struggling to survive. That's just it. They just want to put food on the table and move forward ahead.

And you know, people tell me, they say Victor. We were talking, Danielle and I were talking about when I have to do E-share and the reporting and I look at someone's income and they're getting seven hundred and thirty-three dollars a month and I'm saying how do you live on that? How do you -- and then if you have kids, how do you do that? You've got to pay rent, light, gas, cable and depending on where you live, you pay for water.

West Chester is considered the richest county in the state and they get you for

everything and even, we have a transportation program. Without it, we'd be dead. The busses don't run all the time. They run every couple of hours. After nine o'clock, they stop. So depending on where you live, you can't even get to a doctor.

MS. BENTO-FLEMING: I just want to say one more thing very quickly.

MR. LESIEUR: Yeah. Of course.

MS. BENTO-FLEMING: In terms of like the needs, yes the need is absolutely for full housing subsidies in tri-county, but I have to say that with a caveat, it wouldn't be just reallocating the existing fund because one person, to [indecipherable] one person in, in West Chester county, which I understood was actually the third richest county in the nation with a year's full of rent would be twelve thousand dollars. If we got sixty thousand dollars, we could house five people.

So it can't just be a redistribution of the current pie. That's going to wipe out other programs that people desperately need like transportation since they don't have busses and you probably don't have a car, or even food and

just one last thing and then I promise, I will stop.

In terms of food stamps, there's a law that says if you have section eight or if you have [indecipherable], they're allowed to reduce your food budget because you're getting a full rental subsidy. So we have many people that are in our full subsidy that will go from two hundred to one eighty or one eighty-five to one sixty or one sixty-five simply because they're getting a rent subsidy as if you can spend the money that we're giving to the landlord in the supermarket and it makes no earthly sense. But I just wanted to put that out there.

MR. LESIEUR: So I want to allow this time for question and answers from the audience.

MR. PIERSANTE: Hi, it's David. Just wanted to know, because there's such limited housing in tri-county, have you thought about what incentives can be developed or programs that could be implemented just creatively to incentivize the provision of housing in the areas in tri-county?

MS. BENTO-FLEMING: You mean in terms of building projects?

MR. PIERSANTE: Right, right. People

who have --

MS. BENTO-FLEMING: They have -- there has been housing development projects and I have to say one thing I've seen them do recently, which has benefitted some of our clientele is that they've done a lot of senior housing development and because for HIV infection, it's also a disease now that is associated with people that are older. That is one area where our clients have been able to move into permanent, fully subsidized housing if they got into a senior building and some of the senior buildings will admit at fifty-five.

So I think it's almost like a coincidence that our population is old enough to qualify for the housing that they've really built.

Some landlords feel that it's better to have a subsidy and know your rent is coming because the foreclosures in West Chester, you have no idea. It was scary. You know, I mean people lost their housing of every income level, so some landlords will take a subsidy just because they're getting paid, but you know, there are other landlords that can get, you know, thirty-five hundred dollars a month for a unit in White Plains or Dobbs Ferry or [indecipherable] and I can go on

and on and there is no incentive that I can give them to make them want to rent unless they care.

FEMALE: Good afternoon again. I just want to say and recognize that there are three panelists that are sitting up there representing the tri-county that are warriors and heros and speaking specifically of myself, I really can honestly tell you and I'm going to try not to get emotional, that I would not have thrived, never mind survived if it wasn't for those three panelists sitting there and the other agencies that serve West Chester county.

The resources in West Chester county are extremely limited because West Chester county suffers from affluenza [sic] and we are battling with political leaders who will not support poverty, homelessness, mothers working and never mind HIV, so having said that, I just wanted to play devil's advocate a little bit because the few, very few programs that house people with HIV living with Aids are very few. The roads to get to those resources are very limited. I had to do my own research when I was diagnosed, on my own, to find what was available in a county that doesn't want to admit that these services are

needed.

In my building where I live, there are forty-five units and seven identifiable people with HIV. They don't know that I know all of them, but because I work with the tri-county and the planning committee, I know the services they get and they get their housing through mental health subsidies and through section eight. We are so grossly underfunded and we're so neglected and we're so under-served that it's painful. It is extremely painful.

The other thing that I just wanted to say playing devil's advocate is, those houses that are available, those -- they're in violent and drug infested neighborhoods because nobody wants them anywhere else. They're also stigmatizing so people may not disclose because they want to be able to blend in and live as normal a life as you can.

I'm living a normal life because I'm not living in HIV subsidized housing, but I know so many people who are out on the street from a street level that are not diagnosing, that are homeless and because like you said, the freeze, the housing resources are very limited.

And there's a story that's really not being told and if you go on the street level and talk to people from the street level and not always the information given by politicians and county politics, you're going to see that it is a much deeper and much bigger problem.

But I really want to thank the providers and the panelists for the information because I learned a lot. But there is so much lack and so much need that I hope that being here and being blended with New York City is going to give us new ideas and bring some new light in some ways that we can help tackle the problem.

So thank you for listening.

MR. LESIEUR: Is there anybody else?

MALE: I just wanted to respond to David and thanks. David, when you were talking about, it was several years ago. Father Bob Warring [phonetic] from [indecipherable]. Got brothers, [indecipherable] of the atonement up in Cold Spring. He raised the money to build an apartment building for people with HIV and Aids. He was simply told, you have to put that in Mount Vernon or Yonkers. He wanted to put it up in Peekskill or in Croton, but they said no. You can't have

that here.

So you got to remember the stigma in New York City is not the same in stigma in West Chester County. You know, I get all the time, people say, "Yeah, I know, I know. I feel for those poor people with Aids, but I don't want them here." Yeah, that's the reality of it and so that makes it even more difficult.

And Barbara is right. You know, you go to find a place to live and the neighborhoods they're offering you, you say I'd rather be in prison. At least it would be cleaner.

MS. AIDALA: And also just to piggy back on what he said. A lot of people, they come to us when they lose their employment. You know, there's a higher percentage of people that are diagnosed that if they're not currently employed, they were previously employed, so they may come to us through other networks.

Like we used to have an eviction prevention network when the government gave money to eviction prevention and sometimes we would meet people that were losing their housing because they lost their employment and they would get a referral to us through one of the agencies, maybe

even legal services and wind up in Ryan White services that way.

Or people go into unemployment, maybe they can't pay the rent or they're losing unemployment and now they're dropping down to public assistance and they wind up with us that way.

And the struggle has been to have people actually go and get the additional services that they're eligible for. It's really kind of easy to see us. We're in a very quiet, out of the way neighborhood and we're just all by ourselves as a building and no one knows what's going on there, not even the neighbors. But I think to have people say okay, you're eligible for transportation or food, I've had a hard time because of the stigma. You know, people are willing to get financial assistance, but they don't want any other services. I mean, I've had them crying in my office because they're so afraid of the stigma.

And one last thing about the doubling up or living in your parents' houses, I've had, you know, people tell me, well you know, I can live with my parents, but they make me eat off of paper

plates or I have my own separate dishware or silverware and this is in West Chester. You know, this is not in Iowa or Timbuktu. It's just in West Chester, so I think the stigma is extremely powerful in West Chester.

I think even being a working class person, there's a stigma associated with it. When I drive my little Honda, you know, and I'm passing all these Lexus and BMWs and they're like, Oh, we're so sorry, you're in a Honda.' So I mean, and that's how I feel. I feel sorry for myself once I leave the Bronx. I'm pitiful, but you know, and I really am. It's a really wealthy neighborhood.

You know, I love working in West Chester. I never do my food shopping in upper or mid West Chester. I have to come down to the Bronx or southern West Chester because even the food is cheaper. You know. And don't get me started on the food. Someone stop me.

MR. LESIEUR: So we have time for like maybe two more questions.

MALE: Yeah, I have one over here.

FEMALE: Hi. I just want to say that up in the tri-county area is the worst. Besides the

stigma, the barriers with the transportation, then you have to face how to juggle your medical appointments which is just crazy. If you're not blessed with somebody that can understand your appointments that you have to keep for your doctors, for your own health, then you've got to say working.

Now, I had to work as a home health aid which they don't give you a break. You have to get somebody to cover for you. I had to work seven days a week, so that didn't leave me much time for a support group. So that got me disconnected from everything else.

So these people have done an amazing job for us all, our population because otherwise, we would be having more problems than just a little.

And the stigma, the stigma is still there. I mean thirty years later and we still have that stigma that we got to get past. And the clients, I mean they have those identifiable buildings are, people with a stigma problem are not going to want to go there because they're going to say, oh there goes those people in the Aids building.

They already have -- and the

transportation, if you don't have metro card, you're out of luck. And it's so limited as far as the transportation because there's set times you have to get somewhere. It's between the pharmacy, medical appointments and the stigma. It's all there.

Thank you.

MR. LESIEUR: I got one here. That will be the last one.

MR. SHERWIN: Okay. Thanks. Hi, I'm Howard Sherwin and I work, I work at Legal Aid of Rockland County, so to bring a prospective from Rockland County.

We do have a homelessness problem in Rockland County. There is no shelter in Rockland County for single people; only for families. And there -- I don't know the numbers, but it is an issue and we're grappling with that.

And as you mentioned undocumented people. It is a real, a fairly large population in Rockland County and yes, the health department, the infectious disease unit of the department of health have identified a lot of those people and a lot of them are doubling up, I would guess and are too busy dealing with working and everything else

to access services.

But the one thing I would say about Rockland County is that Department of Social Services is fairly good and we don't hear a lot of the problems that we hear in West Chester about dealing with them, so it's great to have a relationship with your department of social services meet with them and try and foster a good relationship.

Thanks.

MR. LESIEUR: And I want to close. Jason, what can people do specifically to impact change? I know you guys are planning a big event. I'll give you my microphone.

I want to close with Jason. What are some things that people can do to effect change in this area?

MR. WALKER: Hello.

MR. LESIEUR: Okay.

MR. WALKER: So definitely one thing is to join us up in Albany on March 9th. Vocal New York will be providing free transportation for people. I think we have a pick up location in [Indecipherable] Union Square, one in Harlem and one in the Bronx. We're providing free

transportation, a fifteen dollar meal stipend for low income folks living with HIV to make sure we get up there.

And definitely like participate and talk to legislators and get them to really push the governor to really start funding like housing initiatives for folks living with HIV in New York City and throughout the rest of the state as well, right, so that's not only the expense of HASA, but also making sure that we provide enhanced rental assistance for folks throughout the state. Right.

We have the resources, we have the dollars to do it. It's just really, it's just exercising political will to make sure that it happens.

MR. LESIEUR: I want to thank my panel. Great presentations. Thank you everyone. And we do have next [indecipherable]. That wasn't me. I think we're going to close with the governmental co-chair from the planning council, Ms. Jan Park.

MS. PARK: Thank you, Matt. Thank you everybody for being here today and I'm the governmental co-chair of the Planning Council. I'm the Director.

MALE: Closer to your face.

MS. PARK: Can you hear me now?

MANY: Yes.

MS. PARK: Of all people, a deaf person, I'm asking if you can hear me.

Thank you panelists. This was a great panel. We are very fortunate to be able to get all of you here and to discuss tri-county issues. It's part of our integration, bringing tri-county into our city planning process in a way that we haven't done previously and we're going to learn a lot from that process.

Great ideas today. Great conversation today. Now we have to turn those into actions.

I want to thank the chairs of the Needs Assessment Committee; Carrie and Daniel. The chairs of the Consumer Committee; Billy and Katrina. The members of the Planning Council who found the funding in order to put this day together.

I want to especially thank Planning Council staff and the Grand [Indecipherable] staff.

But in particular, Dr. Rothschild, please stand. You cannot believe the amount of emails that she had to endure in order to get all

of these people here. And it really was her perseverance, her late evenings and weekends that pulled this day together and is really a testament to your good works, so thank you very much.

And with that said, I'm going to conclude today's session and we'll do this again. I think it was very useful. We talked three hot topics and those are going to be driving much of the work the Planning Council for the next six months.

Thank you very much. Have a good evening.

(End)

C E R T I F I C A T E

I, Randel Raison, certified electronic court transcriber, do hereby certify that I typed the proceeding in the foregoing matter from audio recording, or the transcript was prepared under my direction, and that this is as accurate a transcript of what happened at that time and place as best as is possible, due to conditions of recording and/or duplicating.

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