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So thank you everyone so the purpose for the today this afternoon is a public hearing relative to the what is now called the MRT waiver plan which is the on of the most important governing documents in New York Medicaid.

I'm going to give a brief presentation on what that waiver is. Its key components. Talk a little bit about some of the changes that are currently under consideration by CMS relative to that waiver. And then a little bit of a repeat for those of you who are with us this morning. I will be just giving a little bit of an overview in terms of some key stats relative to DSIP. So for those of you who are with us this morning it's a repeat but for those of you who are new today you might find that interesting and then at that point we will open it up for public comments and anyone who wants to speak please sign up just outside the door at the registration table. And in what we would ask is that while we won't be purist in this but I think we have over 20 registered speakers so just so that we can allow for everyone to have their chance. If folks could try to keep their comments to about five minutes and as graciously offered as a chair of the PAOP to serve the role of letting you know where you are in that five minute time horizon.

But we just ask that you try to keep your comments within that five if possible.

So with that I'm just going to give as I said a brief.

All right.

OK. Just in terms of where we are with in what is this whatis an 11 15 waiver. Well basically what a waiver does is it gives states the ability to apply the federal government for flexibility basically to waive certain aspects of the Security Act in order to be able to tailor the Medicaid programs to best meet the needs of their citizens. Waivers have always been anticipated and tried in almost every state in the country has had a waiver at some point. But it really is opportunity for demonstration innovation. And in fact there's an explicit requirement that every single waiver that's approved by CMS must have an evaluation opponent. And for those of you this morning heard about the specific evaluation that is required around the DSRIP program. But the waiver itself the overall 11 15 that we're here to discuss the Medicaid redesign team waiver is will have an evaluation done at the end of its five year life. So a couple of things important to know about waivers are that as a citizen you can think of it maybe as like a contract between the state federal government. Within that contract there are special terms or conditions or SRCs. In the case of New York Medicaid those STCs are important that govern very significant portions of the program. They're negotiated between the state and the federal government and agreed to it in eventually what becomes the waiver agreement. We also report quarterly and annually to the federal government on our implementation of the waiver requirements. And we as I said are required to have an independent evaluation done at the end of the demonstration period.

Waivers must also be budget neutral meaning that while the federal government will waive certain provisions of the Social Security Act to give states flexibility. As a result of that flexibility we can not have the program cost the federal government more with that flexibility. So that is called budgeting neutrality and it is a key negotiating point in all waiver negotiations.

And typically although not always demonstrations periods are five years in length. And people may be familiar with in late 2016 got approval from CMSfor a five year extension of the existing MRT waiver. And so we are in the early stages of that. DSRIP which was approved before that extension obviously has an ending period of 2020 and the extension of the overall waiver that contains DSRIP had no impact on the DSRIP time period. So in terms of the waiver itself and a little bit of its

history. The waiver in its most recent Newell actually had its name changed from being the formerly known as the partnership plan waiver and now the New York State Medicaid redesign team waiver. Its been in operation since 1997 and it was initially designed and in fact continues to be used as the state's primary vehicle for moving services and populations into managed care. And thats been extended multiple times and we have amended it multiple times to particularly not only for DSRIP but for many of our moves to manage care that have been done over the years. New York's 11 15 was as I said renewed in December of this lat last year. So its effective through March of 2021 and the goals of the waiver are the goals of the Centers for Medicaid Medicare services the triple aim. At least those are the goals for CMS today in terms of improve quality improve health outcomes and reduce health care costs. A number of other initiatives have been built into this program over the years including obviously our key DSRIP goals which are mentioned here on the slide.

So in terms of the major programs that are governed through the waiver you have virtually all of our managed care products are governed here including our mainstream managed care and our Harp's the health and recovery plans. Also we use the most people receive their home and community based long term care service through through the managed long term care program. Which is a key part and parcel of the program significant change was the move away from fee for service to manage care for those long term care supports. Also as mentioned is obviously DSRIP which is a key part in what we were here discussing earlier today. And then with this also is designated state health programs is where the federal government provides States with matching funds from programs that otherwise normally wouldn't be matchable. But they match those funds to support demonstrations that their supportive of. DSRIVY as it's referred to is a funding source for our DSRIP program. So in terms of movements that are currently pending to I think exciting things that we've been working on for a number of years that are now being considered by CMS. First and foremost is the children's assistance transformation. This is our efforts for really for high needs children to those with significant behavioral health needs. To be and children who are in out-of-home foster care placements to be able to move first into health home and then into a specialized version of managed care. And so that amendment is currently pending with CMS. And then also we have a Amendment pending with them around OPW DD and moving that population into managed care. The first step in that effort is a health home like Froddick specially designed for people with developmental disabilities.

But then ultimately there's a schedule to move first to voluntary and then eventually to mandatory managed care a transition period they'll take us into actually the middle part probably of the next decade. So that is sort of the key facts about the about 11 15 waiver as a whole but want to just as I said give you a little bit of an update of where we are with regards to DSRIP. So first and foremost DSRIP is a performance based program. In order to receive reimbursement either PPS has to be able to demonstrate quantitatively that they have in fact either implemented projects or have improved outcomes for Medicaid members. And so far at least through the second year of the demonstration the PPSs have earned ninety five percent of all potential funds. You can see there they've earned 2.5 billion out of a possible $2.6 billion in terms of funding. And so while it was mentioned early this morning that the challenge that PPS has grows over time as more of their work moves away from the process measures into outcome measures. But at least so far they're doing what has been asked of them. So in terms of PPSs and how they're performing. There's lots of ways to look at that. We spent a considerable time looking at that this morning. PPS have distributed over $1 billion in funds to their partner organizations. That's through the DSRIP year or the third year of the initiative quarter two. Also PPS is engaged through its various projects 530,000 partner organizations.

That's it's a cumulative number in the sense that you have multiple providers who participate in more than one project for a PPS. Also key measures for DSRIP where the reduction in avoidable

hospital use. This dates back to 2009 when Commonwealth found that New York ranked dead last in avoidable hospital use. And to wrap the Medicaid redesign period that has been a focus of ours. And the PPS is a particular their primary measures are reductions in avoidable hospital use. In particular potentially preventable readmissions and ER visits. So far than the news is good that through the initiative that we've reduced readmissions by 15 percent E.R. visits by almost 12 percent. And when you actually project that then out over the full waiver period assuming that level of performance is maintained you see that we actually exceed the goals that we laid out in DSRIP which was a 25 percent reduction. On this slide you see the readmissions. I note to the right you see the chart that shows the breakdown in PPSs in terms of sort of bands of performance you see pretty significant variation. I also note that this is earlier in the period this is through the second years of demonstration. So sort of somewhat early days but overall we're moving in the right direction. In the case of the readmissions potential for a 33 percent reduction. And here in the case of ER visits a little closer to the goal. In this case about 27 percent reduction. So other ways to look at how PPSs are performing. So far they've successfully implemented 31 projects that's through demonstration year two. 95 percent of the D-y two project requirements have been successfully implemented and PPSs were scheduled to complete an additional 20 projects through demonstration year 3 Q two. So that's the overview of where we are. If you're looking for more information on anything that I talked about here you can find that here. There is a separate page on the 11 15 waiver.

You also find special pages on our managed care DSRIP and as well as OPW DD has its own web page specifically around its moved to managed care for the OPW DD population. Some additional books and then some additional sites here including the CMS home page where I believe they still post all of the 11 15s that you can find in the country as well as the overall Medicaid national Medicaid homepage is found here as well. And so with that that's the end of the formal presentation. And I think we are ready to open it up for public comment. I think last I checked there was about 20 speakers. 25 speakers. So with that I would like to do is call the first two speakers up to the mikes off to my left if we gather the first speaker and then to the right the second speaker. That would be great. So thank you very much. Please just identify yourself. The organization your representing and that would be great.

I'm Terry Hamilton and my colleague is Matthew Maney. We are the co-chairs of the New York City DSRIP HIV Coalition. Thank you for this opportunity to testify on behalf of the delivery system reform incentive payment program performing provider systems in New York City that are implementing HIV related projects. Eight PPSs in New York City have established a DSRIP HIV coalition to coordinate efforts and share best practices as the PPSs work to implement their respective HIV programs. The coalition has formed standing committees focused on the exchange of information with respect to five key areas. The use of electronic medical records and data. Opportunities to enhance HIV screening and linkage to care. Peer based interventions. Prep implementation and viral load suppression initiatives. Coalition and standing committee meetings are attended by a variety of PPS representatives including staff from PBS lead organizations PPS partners and stakeholders and technical experts and other guests as appropriate. Collaboration with community based partner organizations is an important part of the PPS engagement in the HIV projects. And this is confirmed by the participation on each of the standing committees of staff from PPSs community based organization network partners. Among the community based partners who have been most active in coalition and standing committee meetings are VIP community services, housing works, Bailey house, the Alliance for positive change, apertia, bridging access to care in bright port bright point health. New York City Department of Health and Mental Hygiene acts as convener of the coalition and immediate care provides technical assistance support. Coalition meetings are helped to build are helped to build the knowledge base and understanding of best practices that they will be key in the successful implementation of domain four HIV projects. Highlights from standing committee discussions to date are summarized below. Electronic Medical Record and data utilization. The coalition and its EMR and data utilization committee have invited

experts to meetings to discuss how regional health information organizations, the state statewide health information network for New York, and private health information exchanges can help improve care coordination for patients. Mt. Sinai PPS, the Bronx Rijo and Halifax gave presentations about benefits challenges and various information sharing. And participants in those meetings were able to explore complex questions related to rules for accessing HIV patient information through Rijos. Participants discuss the benefits of efficient sharing of information among both health care providers and others involved in patient care. We believe that smart coordinated care decreases redundant tests and results in decreased costs and better administration of patient care. In addition to the work on information sharing, the 2016 New York state department of health requirements for HIV care Cascades were used as an opportunity for the EMR and data utilization subcommittee to hear from organizations. New York Presbyterian, Housing Works and Mt. Sinai Institute of Advanced Medicine about how each organization CARE Cascades were developed. What limitations were encountered and how the care cascades are being used to inform HIV care.

Thank you Terry. The HIV screening and linkage to care committee.Tthis committee is working to develop tools and resources that can easily distribute among PPS members of the coalition to support improvements in HIV screening testing and linkage to care. The screening and linkage to care committee has identified key tools that could be easily shared across organizations and developed a set of standard points to be included with the dissemination of each tool. Such as target audience, details on how the tool was developed and can be used. And the key message is that the tool is intended to communicate. The tools reviewed to date include a script for use in the E.R. when offering HIV testing. A sample memorandum of understanding for linkage and referral activities and a sample discharge planning note to address ongoing linkages to HIV care. The group is planning to conduct key informant interviews with hospital and community based HIV screening and linkage programs to identify best practices across five areas. Identifying reaching and assessing high risk populations. Partnership in collaborations, staffing patient involvement and communication and program evaluation. A report detailing the process and identified best practices will be shared upon completion. Our next committee a peer based interventions. The coalition is advancing efforts to implement peer based interventions as a strategy to improve wellness of people living with HIV.

You are totally. But if you could you could wrap it up.

No problems.

Thank you.

We'll cut to the chase. The committee hosted presentations from three provinces experienced in hiring peers including the Bronx health access PPS. The Alliance for positive change in housing works. Helping people to assess certification to be a peer and what that would mean is a fulltime job. We've also done extensive work in prep implementation including working on better understanding the barriers to uptake and adherence among key populations. And finally we've been working on a viral load suppression Committee. Taking different approaches to increase viral load suppression to achieve our ending the epidemic goals in improving health outcomes. PPS is including ma mamaties in community care of Brooklyn and Mt. Sinai have collaborated to develop plans for viral loads and oppression initiative and worked with housing works and others to identify best practices.

Okay thank you.

Thank you for this opportunity to talk about our efforts to implement HIV related projects. Perfect

timing.

Thank you very much.

Perhaps Jason said it. We're going to tell you when you have a minute left and then when you have 30 seconds left. And we'd like to hold the presentations to about five minutes because we have a lot of people here today. So OK with you.

Sure you can just pinch me.

Number three could come up. We'd like that. And thank you for your presentation. Introduce yourself please.

Sure. Hi my name is Christy Park. I'm the executive director or the CEO of the Coalition for behavioral health in New York City. So we serve about 500,000 new yorkers with services via our membership which is about 140 agencies that provide substance use and mental health services. So I want to thank you again for this opportunity. A year later to come in and share some of our comments. And effective treatment and recovery and resiliency for people with behavioral health disorders includes an array of services that fall under the banner of social determinants of health. My remarks today will focus on the big picture recommendations but also be submitting written comments with more expense extensive details. The comments today will focus mostly on the services and the problems our member agencies have identified with us about how the services were designed. Ramifications of not addressing these concerns and potential ways to improve the deaf deficits. Many of these recommendations are ones that we've shared in the past either in this form or other forums and we will continue to provide that input and partner with you all. I'd like to begin However for my members. One of the things they wanted me to convey was really recognizing the precedents of the state for addressing this concept of social determinants. We want to thank you for that effort because it fits within our model of how we want to serve people. Those include the services to be realized under the triple aim and ensuring that DSRIP program goals include the social determinants of health services.

The recent improvements in the contracting and providing payment for those services by the PPS and we're grateful for that in a number of other places so we know you are hearing us and we appreciate it. Of course we're going to keep pushing. As far as integration of services goes including integration of behavior health and primary health services. And with this attention to social determents makes us especially within that to stabilize the lives of people. For example in places like supportive housing. There's a long history in the provision of care for special populations. For example the public health services act requires that the health care for the homeless program providers integrate behavioral health services into their primary care model. HIV care model. From our previous speakers includes primary care which grew out of the need for services such as housing and reached into the realms of economic stability social cohesion and participation with health literacy education nutrition. So we think there's a way forward in many areas where we can learn from these other examples of where integration happened and also from the areas where there were problems then we're gonna be looking at a coalition at those areas. There is a parallel between what we went through and what those other historical programs have gone through. Related to volume. Community based organizations frequently do not have the volume necessary to make certain services such as health home assessments and HCBS referrals worthwhile. I know many of you know that. Nor do they have the infrastructure to support data collection and analysis contracting and credentialing. And importantly adoption of electronic health records and participation in health information sharing platforms is really critical to our success. And also just making sure that we're doing what we set out to do.

Several of our members who provide these services expressed major concern on these areas and are considering giving up their contracts. One of our members reported that for every dollar they received under the services they incurred $4 in costs. Another member has shared that they've invested precious agency dollars in excess of hundreds of thousands of dollars in the last two years to invest in both HCBS and DSRIP participation and the return on investment for them is not there. They're not sure how much longer they can sustain this unfunded mandate. Similarily they function on a minimal margin which couldn't support assuming any further risk or diminished reimbursement which may be passed down to them from their upstream partners. So they're really concerned they want to participate but they're feeling the pinch. Well we do support rate increases and adjustments as you know the coalition also believes there's possible ways to drive access and volume through streamlining and efficiencies and standardization and expanding billable services and accounting for secondary costs such as travel time. We looked forward to further conversations on these areas and we'll be putting that to our final comments. I was happy to hear.

About a minute.

Okay. I was happy to hear in the morning session a question about what was the biggest chunk of PPS spending and the responsive workforce in HIV. We share those concerns. That is that those are the number 2, 1 and 2 areas for us. My testimony will go into that in further detail. Without a robust workforce we're not going to be able to achieve what we need to do. Our workers both need the resources the COLAs, the competitive salaries that we can retain and recruit them. But they also need metrics that reflect the work that they're doing. Otherwise we're going to demoralize the heart and soul of these programs. So I encourage you to think creatively with us about ways to increase their capacity to deliver services but also ways that we can support and think and that includes things like salaries and things like that but also things that help them with credentialing covering the costs for social work licensure. All kinds of ideas that we'll be putting in our testimony. Competitive salaries in regular cost of living will really help that. And finally one thing that I wanted to say to be very clear is that we are absolutely behind the concept of where we're trying to go with DSRIP and where we're trying to go with 11 15 waiver.Qwe want to be partners in that and we're grateful for the infrastructure funds that have come our way. We want more that we want to be able to compete as fair partners with our friends on the healthcare side both through the workforce and also health information technology. You'll have my full testimony. Thank you.

Numbers Three and Four.

And after three has presented it five could come up so that we can keep moving. So number three and number four. Is there a number four. You're four. Come on up to one of the mikes.

I'm sorry about that.

That's all right hold on. Who's three.

OK well go for it four.

So I'm a family peer advocate and Medicaid managed care consumer. I'm also a caretaker for two vulnerable individuals one with a developmental disability and the other is a seriously mentally ill individual. So I want to cut to the chase. I think that the DSRIP and PPSs should include consumers and community representation in their governance structures as they currently do not. Consumers have a right to understand the implications of EVP and how it might affect them. In addition to revisions to the managed care bill of rights the state should insure consumers their advocates and anyone charged with assisting them that they're informed about and know about EVP concepts. Also the CAGVP work groups should be transparent and meeting minutes of such work groups

should be online and accessible as they currently are not. The state's care management for all initiative which must ensure true access and meaningful care coordination. As of now there's been no surveys or feedback collected from health home consumers directly which is a real shame since that's been around since 2013. Home and community based services are an entitlement particularly those with behavioral health issues who are served by health and recovery plans. HCBS services as per data from the Medicaid managed care advisor peer review panel as of now for almost two years later are seriously under utilized and access to HCBS services should be made more x x quicker quicker. Yeah I think that a private independent consumer assistance advocacy group should be available to children and the IDD population as they transition to managed care and or health homes and CCO's. Special attention and engagement opportunities should be paid to this transition to Medicaid managed care for vulnerable populations including children people with intellectual developmental disabilities traumatic brain injury et cetera. Furthermore Medicaid managed care organizations and products such as harp and Medicaid managed care should be held accountable for their lack of care management services and plans of care especially when health homes repeat repeatedly fail on these plan of cares. And as per MCO and D.O.H contract state. Outreach should not go on iver and over in in that different health homes can bounce a consumer back and forth billing and under outreach for an endless period for two to three months at a time. Last I think that clear defined roles for the New York state government entities like OPWD office of family support services. OMH and office of substance abuse services should have a clear and transparent role with list of responsibilities and duties in this transition to managed care as well as health homes and CCOs. The same should also go for the local councils of mental hygiene directors and regional planning consortiums both of which New York State Department of Health Web sites offer little to no information. Thank you.

Thank you very much. Are you number four or number five number five.

Yes. Did Number three come in the room. OK. You could come up please.

Good afternoon my name is Alyse Thoreau. I'm from the Nassau Queens PPS. And I wanted to thank you for the opportunity today to provide you some information on some of the efforts that the IQP has been undertaking in terms of community engagement. So recently as of September IQP has launched our CBO innovation fund and this is a dedicated centralized effort to engage with Tier 1 CBOs. Our staff that are working on this on this ffort come from a working in the CBO background. And we purposely designed it to be very easy for organizations to access. We made our contract five pages not 40 so that organizations do not need significant legal resources in order to engage with us. And our primary goal at this point is to engage with organizations primarily in our areas we have designated as hot spots to really leverage their expertise and their communities and their populations that they serve. And then from there to learn also about what pieces are in place in those communities that we could further support to develop innovation to support the goals of DSRIP. And I wanted to share with you some comments from one of our organizations that we've contracted with who unfortunately couldn't be with me today. Steve Chassman from the Long Island Council on Alcoholism and Drug Dependence which is a tier one CBO. LICAD is proud to have partnered with the Queens performing provider system and grateful to be supported through the CBO innovation fund. Through this collaboration LICAD will be offering professional assessment and training options to the PPS to maximize engagement screening and referral systems as it relates to people with substance use disorder. Leveraging LICAD's longstanding expertise and engagement of the population in the community. LYCAD Services will be geared towards improving quality treatment on demand effective aftercare and professional follow up to reduce emergency department admissions and promote patient wellness.

This part partnership will serve to foster professional connections between the hospital providers community based organizations in order to best serve our common communities and meet the goals

and objectives of these vital initiatives geared towards better health and effective care. So that is an example of one of the organizations that we're working with right now to really leverage their expertise and bring that expertise into the leadership rooms of the hospitals as they strategize and develop new missions. Thank you.

I think he wants to talk to you privately.

Sure.

Six.

Bill Meyer senior director of workforce of Staten Island PPS. I'll give you an update on where we've been and where we're going. Based upon a partner survey two years ago and continued contact with our PPS partners, Staten Island PPS has provided over 300,000 hours of project related workforce training over the past two years. That work is now moving beyond designing and implementing training.

We have partnered with 11 99 SC UTF to provide ongoing trainings and have also incorporated clinical best practices from XT health in our other trainings. More than 50 of our partners have accessed our training offerings. Many of them from smaller community based groups. We are with the College of Staten Island to provide certificate programs and a community health worker care management. We provided scholarships to students in need in the areas of social work and mental health counseling. This training has permitted us to bring training back home to Staten Island. Sparing our residents tracks outside the borough. We have provided consultation of assistance to the College of Staten Island to create curriculum to support the development of an M.S. in health care management. Our partnership with CSI has led to the creation of a workforce consortium designed to build and implement a sustainable workforce solutions going forward. Our sick one significant cultural outcome will work training has been a break down the old silo a single institution training. Many of our trainings now have multiple partner participants and they all go back learning the same best clinical practice. We convened focus groups of our trainees to learn how they apply training provided by the PPS. To address workforce transformation challenges we have engaged the TUDA group to help partners implement lean process redesign. The lean approach has yielded more efficient workplace processes designed with line staff and organized labor. To address future workforce transformation sustainability. The PPS has been pursuing with the office of Congressman Dan Donovan, the College of Staten Island, our partners and SEIU eleven ninety nine TEF. Potential opportunities to build apprentice training programs to create predictable hiring pipelines to address some of the chronic recruitment and retention issues facing our partners.

The PPS is jointly formed what the college of Staten Island. This consortium and creating best in class training for our healthcare partners with partner and labor input. Nursing home partners recently spoke to us about the need to create a predictable and sustainable supply of certified nursing assistants. We face a tight labor market often created by prohibited transportation costs so candidates don't come from off island. We circulate the same group of people over and over again in and out of every nursing home. Apprentice training creates the opportunity to establish a steady supply of trained staff onboarding into each organization's cultural values.

Review the apprentice program for CNA is the first step in creating new job opportunities for those seeking entry into health care jobs. And a robust apprentice program. For example the CNA may access further training to advance to LPN RN or pursue an associate's degree with emphasis in health care. Later a bachelor's degree which could be a gateway to a job as a health coach. The apprentice program also provides opportunities to build career ladders, promote career advancement for incumbent health care workers, and in the end build a common curriculum where staff at any

institution have learned the same best practices. Thank you.

Good afternoon my name is Becky Hall and I'm with the 11 99 SEIU training and employment funds or TEF. The TEF has been working on federally registered apprenticeships since 2015 and we have two occupations currently registered with US to. Sorry with US Department of Labor. Inpatient medical coder and community health worker. These programs are run in partnership with eleven ninety nine Mount Sinai Bronx Lebanon Hospital Center. We were working with the New York state to register these at the state level. By the end of 2018 over 70 CHWs will successfully completed the registered apprenticeship program at Bronx Lebanon. As part of this model all 70 full time jobs and wages wage increases as they earn and learn on the job and serve the communities from which they come. We're currently working with both union and nonunion partners. As we look to expand the registered apprenticeship model into additional occupations. We look forward to continue our long standing partnership with the Staten Island PBPS and exploring the registered apprenticeship model for CNAs and skilled nursing facilities on the island as part of our district work. Thank you.

Seven were you seven. OK. We have eight and nine.

And then if 10 and 11 would be kind of on call.

Good afternoon. Thank you for the opportunity. My name is Jun Ca Chin. I'm a registered nurse at one Woodhull hospital in Brooklyn New York. I'm also the president of New York State Nurses Association Health and Hospitals and mayoral Executive Council. NYSNA is an organization where 40000 members across New York State representing nurses in a public and voluntary hospitals and other health facilities. We are committed advocates for our patients fighting to improve the quality of health care and universal access to care. We are very concerned about the new approach that U.S. Health and Human Service appears to be taken to the value based payments which seem to conflict with New York State's goals. Two serious examples. HHS has been canceling important Medicare bundle payments for cardiac and orthopedic procedures and movements to make all the previously mandatory programs voluntary. As nurses we must express our objections to these changes that we believe risk the patients. The shifting ground policy makes us very uncomfortable. Constantly changing directors make the great difficulty in planning on a hospital level. While hospitals have been pushing forward with DSRIP process. Changing structures and renewed efforts to figure out how to carry out Value based payments on a much larger scale became cumbersome. Altogether these changes constitute obstacles in our view. We are disturbed that the current administration may well in fact be undermined in many of the original goals of the DSRIP.

In addition given that the goal of the 11 15 waive is to shift our medical system towards value based payments we are very concerned that a renewal of the waiver may be in jeopardy. It is not all clear that all of our hospitals will arrive and require benchmarks.

The Senate necessitating a continuation of the 11 15 waiver. We are also going to express some concern about the state of the one city PPS. Previously we had really appreciated our relationship with PPS. They valued the input of nurses in the health care process and NYSNA New York state nurses association was well represented on various PPS committees including the governance and clinical committees. We are able to provide useful thoughts about the PPs should function moving forward. However with the recent departure of top leadership from one city the PPS canceled several meetings which is very frustrating for us. Along with our labor unions we have expressed our concern about the lack of forward movement to the leadership of H and H but to date have received no response. We are where we are that leadership has not taken this problem seriously enough and wanted to advise the POAP of these were worrying developments. Thank you for the

opportunity to be there.

Next. And could we have.

10.

10. Thank you.

Hi good afternoon. My name is Pat Kane. I'm a registered nurse and I'm the treasurer of the New York State Nurses Association. Thank you again for the opportunity to appear before you this afternoon. NYSNA has been actively involved in DSRIP since its inception. We serve on workforce clinical and governments. Government committees for 20 performing provider systems across the state. As the PAOP is aware we've consistently been asking for transparency in workforce reporting at various DSRIP hearings. We're very appreciative that the DOH has chosen to share some of the workforce reports on the DSRIP Web site. However none of the compensation and benefit reports from year one to date are to be shared with the public and we really don't understand that decision. The reports were already aggregated to ensure that no single employer was identifiable. So we must ask why is this important part of record keeping not being shared. The compensation and benefits reports from year 3 are going to be collected soon. These will provide valuable data on how compensation is changed from year 1 and what effect DSRIP is having on our workforce. It would be really unfortunate if the DOH would to continue withholding this data from the public and we would like to request that the DOH post the year one reports online and ensure that the year three and year five reports be shared as well. You have made several recommendations to improve the PPS reporting for spending on the quarterly reports. There has been some improvement but substantial gaps remain in what is reported so that funding for different categories can be tracked.

We need to know exactly what the contracts with community based organizations are for potential payment and what was actually paid. It seems appropriate that we know on what basis the rate of compensation was arrived at. Another category that needs additional attention is updated reports on primary care expansion and community based settings. Overall we have concerns that the appropriate CBO projects be properly funded and supported. I serve on committees on the Staten Island PPS. And we would really like to have a more active role as Judith previously talked about on the one that they serve on several of our meetings have been canceled and we would like to see you know more work force meetings scheduled and have a more active role given the opportunity. I just wanted to talk a little bit about case management. We've had a really successful program of mymaties with traditional transitional care nurses which was really something that came out of this program and that program has really been going great over there. They've actually integrated those functions permanently into the case management functions in the hospital and they've been seeing great results. Methodist interfaith and actually Kings Brooke are also going to be starting those programs and we think this is the kind of forward thinking that will really enable us to transform the kind of care that we're giving in the hospital and ensure proper discharge and follow up. You know and that the pilot can really extend the goals DSRIP past year five right. That's our ultimate goal. We are disappointed on Staten Island that we haven't been able to pilot that project. We do have kind of a crate crisis in case management staff on Staten Island. As someone previously testified our labeled pool is a little bit smaller and you know we have a great need in the hospitals for more case managers to effectively carry out these objectives. Thank you for the opportunity.

Next we have 11 and 12. 11 12 OK.

And 13 and 14 in the wings please. OK.

You're 11 or you are 11. OK.

My name is Miss Sharone Milliner. I'm from NYRPS New York state rehabilitation psychiatric services. I sit on the board of directors as a senior peer advocate. We've been with this group from the beginning and we have a lot to say about how the money is spent and how the money should be spent. Several years ago Mr. Harvey Rosenthal the executive director has indicated to DSRIP to spend money a particular way by the hospitals. We would not be sitting here wondering what is coming out of Washington D.C. if they had implemented that plan. Two. We just got from Jason and the others that the value based payment of health homes didn't work or didn't work for all of everyone but it did work for some. We're asking for collaboration with the board of directors of NYRPS with DSRIP in order to have the money. On November 3rd you put out November 2nd or Novmber 3rd you put out a p b so to speak that you giving money to particular organizations. We'd like to follow that money. That being pulled right now on the board to ask DSRIP in order to follow the money because it's very important not just in the same funds as Cuomo said but also to get the health outcomes of patients. Which is most important. This is what we're concerned about. The prove outcome of the health of the of the clients of the patients. 3 we have we did a a call it with Miss Laura Kessel here several months ago with Godfrey and Kruger on geriatic care. We have a death of a geriatric care paid doctors and we specifically with the psychiatric now I have a psychiatric diagnosis and I went several years ago that a psychiatric diagnosis. When your femur can come back at any time when you're in menopauses. I was hospitalized for that very same thing twice. Earlier this year and I just found out that one of my colleagues on the board of directors had to do the similar thing. So I asked Miss Sullivan of OMH to follow this type of training with geriatric psychiatric geriatric care. More carefully to put more more funds to it. Thank you.

Yes. Good afternoon everybody Jim Carrey I'm representing RAIN today regional aid for interim needs. I'm one of the directors and RAIN is a big social service agency in the Bronx. We provide a lot of services that touch on Social Determinants of Health. We provide home delivered in congregate meals senior centers case management a home care program housing and a few other things along along the line. Record rain recognize the importance of this trip early on in the process and within the programs that we've participated in a lot of them from the beginning you know from when their just the coffee clucthes into what they've grown into today. I'm here to talk about our experience with Bronx partners for healthy communities. We've been a member and worked on a lot of committees with them. I'm on the Workforce Development Committee with them now. And one of our real active groups is the community engagement group and that's about 20 20 CBOs and we've been working together since December of 17 about a year now and we've completed our key projects our petition participation and collaboration with this group has been a valuable and educational experience on many levels.

Part of it is I went out into the community and doing our health literacy and actually got a lot of good feedback from what's going on in the community on the ground level that I was able to bring back to the group and we could modify our procedures in our approaches and actually all of us in the group have done that and worked collaboratively collaboratively you know to get this right. The work group also collaborated with Bronx partners for healthy communities to create a resource directory and so all our group got together and said we're recognizing the importance of community based services and the social determinants of health. Robert Wood Johnson recently did a study where it said 80 percent of health care is provided in the community. 20 percent in the doctor's office or the hospital. And what we've found in the not for profit community in the CBOs is that a lot of times we can say oh yeah we prevented the hospital visitation we stopped the E.R. visit but we've had no ways to quantify this or qualify it.

And I think working with the CBOs I mean working with the PPS's this is important for us because then we can put a number in a value to the services we provide. And also trying to look into the future and seeing where the system is going. What kind of services that are in our wheelhouse can

we implement in preparation to be a partner going forward in a sustainable way provide services that show a real return on investment that we can then turn around and maybe market to the MCOs and the MLTCs and possibly other insurance carriers. One of my other roles is I'm also a trustee with the eleven ninety nine SCIU benefit fund and you know we're looking at value based payments and you know there's another opportunity for some of these addressing some of these social determinants to help if we can put a price tag on and say we implement this. You know we can expect this amount of savings and reduce your cost. So we think these are for CBOS. And for the way RAIN is looking at it I think all of this is important experience. You know just to give you one example of what we've done retrained all the directors so we have a real core staff that can do stand for diabetes and we're looking into expanding that which is you know one of the cores from one DSRIP programs.

So as DSRIP evolves and we've had experience even though we're not working with DSRIP on this. We have the experience and the expertise and the track record that saying yes we can go forward and maybe market these to other other institutions. So again I want to thank you for the opportunity to speak to you today and look forward to continuing the collaboration. Thank you.

14.

Okay. I'm 13.

You know it's good this isn't a math class then we'd really have trouble. All right. So who's going. You're going first.

I guess so. How are you doing. My name is Hindi and I'm the chief information officer for Rockland paramedic services in Rockland County. I also serve on the board of directors for United New York ambulance network and I'm the immediate past chairman. Thank you for the opportunity to address you today to share the exciting work that we're doing on the ground in Rockland County. Just a little bit about us. We've been serving Rockland County residents for the more than three decades as a paramedic first response service.

We also have a behavioral health response team serving as a community based organization. That's a mental health crisis team in Rockland County. We've added a second unit since we started that in April 15. In addition to that we have a home based crisis intervention unit that we just started last month. That's a single clinician targeting adolescents in their homes for four to six week period carrying a very small single digit caseload and that's funded throughout the throughout year.

In addition to that we provide critical care ambulance service throughout Rockland County to and from hospitals inter facility transports. So as emergency services first response paramedics we are in a unique position to make early and impactful interventions and the collaborative members lives. That's why Rockland paramedics is pleased so pleased at the Montefiore Hudson Valley collaborative as quickly recognize the critical role of paramedics and the continuum of care.

This has led to Rockland paramedics making invaluable connections to other parts of the MHVC networks like the behavioral health community for example in ways that benefit all of their members. We're very proud to work with the Montefiore Hudson Valley collaborative in the earliest days of the DSRIP prope project creation up to the collaborative latest launch of the innovation fund. Rockland paramedic services will be using innovation funds to transform our role from patient transportation to patient support with the mobile integrated health care project providing community paramedic services. By partnering with Nyack hospital in our community select paramedics will receive specialized training in home visitation. The collaboration will also implement the first of its kind HIPAA compliant smartphone application called Twiage. That's not a

mispronunciation. This app enables our first responders to exchange live data about patients symptoms through videos photos voice memos and text messages to medical control physicians in Nyack hospital's emergency department. With real time information and GPS tracking for incoming ambulances. Nyack clinical leadership can guide our paramedics and directing patients to the right level of care reducing unnecessary E-D presentations. Rockland paramedic services has already been flowed over a hundred and seventy five thousand dollars to launch this project with an additional 175 coming in 2018. We feel all of our community based organization products help accomplish the goals of the Triple aim. We're excited to participate in the collaborative efforts in reducing unnecessary D visits and continuing our efforts at providing excellent community based care in Rockland County. Thank you for the opportunity to speak with you today.

Thank you.

Good afternoon. My name is Laticia Gibbs. I'm district coordinator at health people. I am also corsotial member of community for health equity. Thank you for someone to come and speak. I have a couple of issues that I want to bring before the state. One is with the definitions. I was part of the cultural competency committee and being a part of that committee was really the only platform where the community had a voice in this whole DSRIP process. So I just want to stress that as you know it is very sad that that committee went away. I also want to stress about the definitions we started talk around defining CBOs and we was halted with that conversation and we was forced to use the definition used by the created by value based pay VBP task force on that definition does not. It's not a one size fits all. It does not really stress who CBO's are. And under that definition. The problem I see is that it allows other organizations to come in and claim that they are a community based organization and be entitled to funding that they should not be entitled to. The second thing is cultural competence in diversity. I have a problem with that because the value based payments has flaws. There was no people of color on that task force. There was no community members a part of that task force I really want to know how was that definition created and where did the community come in you know creating that definition. Also with contracting with CBO's. Jason I want to thank you for listening of the importance about the social determinants of health and as you know it's addressed those social determinants of the health that I stressed at the last public hearing is we must involve CBOs in a process from the beginning not at the end not just say we at the table and not really being you know compensated for the work we are doing and being under value for the work in the work that we bring to our community. So we are the trusted brokers in our community. So I stress that is very important that the PPSs show you know really have set the table and really involve us in that in that process from the beginning. We asked the state to intercede on that and we have had no response from that some you know eager to hear feedback from that from today. Also the lack of transparency with the funding within the PPSs you know some of them are not using all of their funds and it's going right back into the hospital as they call it indigent pool of money. So I ask who get to say where that money go is it stays in hospital or you know get the say like what part is being put back into the community and of community based organizations. The last thing I must stress and I'm a thank you very much for allowing communities together in this city wide effort for the city grant for the state grant that you provided us with. It's very important that we continue this work and we're doing such great work in rebuilding such a strong network.

So in order for us to continue this work we are pleading with you to please renew the CBOgrant so we can take it further. I want to see DSRIP succeed. I want to see it pass beyond the five years that is designed you know and us working together really working together and having CBOs at the table will definitely make that happen.

Thank you.

15 and 16 16 Milenko 15.

Thank you for this.

Would you like us to pull the mike down for you. Can you pull the mike.

I'm a little short. My name is Milanc Barigold. I'm director of special projects and program manager at BCID the Brooklyn Center for independence of the disabled. And I totally agree with the last speaker social determinants really are part of health and wellness. In particular my population the disabled population has very specific needs that are not being addressed. So for example accessibility. And examples are large print for the visually impaired. ALS for the deaf. Wheelchair accessibility. Medical equipment that's cannot be used. So that's one issue. We want to be. We want to have our share also of all this money that is available. I don't see us sitting at the table with PPSs. I do want to say though I've been Program Manager of a community health worker program so someone else before mentioned community health workers. We are in partnership we have one grant with an MCO in partnership with Empire and in that pilot program initially and we now have a second contract with them. I hired and trained people with disabilities to get peer support. In this case the phone peer support to their members who had disabilities and chronic conditions. This program has had great success especially in terms of less E.R. visits and just improved health and we would like to see more of that. So thank you very much.

You're welcome. Number 16 17. Come up please.

Good afternoon. My name is Anthony Feliciano I'm the director of the Commission on the public health system. We're also a member of the steering committee of communities together for health equity. I just want to put on the record first there are institutions that are getting funded or have been funded and ones that are going to get funded given this narrative of around communi engagement and community based organization involvement. And I want to put on the record that this idea of strategic planning that we are grateful to the state and the federal government to provide to community for equity and the other two entities upstate in Westchester. Is being told as if it just came out of nowhere because of the goodness of trying to move something forward. And this was a two year fight and then a one year wait to get to this. You know we're grateful to the state for this. I want to be clear about that that this and this fight continues around committee based organizations being really engaged in DSRIP. And it starts with many areas contracting now understanding who'd be in contract terms of community based organizations. Are they community based organizations that are really contracted. The fact that the flow of funds are not transparent in terms of the reporting.

You look at the East Harlem alone and some of the groups that have done some work there like 5 percent of the flows of the funds have just come out of the PPSs to the CBOs. This is unfair and some inequity in terms of the engagement and I understand engagement can look differently for neighborhood's engagement can be very hard to decipher and put together. But we haven't even developed metrics and functionality for engagement defining that.

And so I think it's important that we also have a hearing that gives more time for community based organization to discuss and go do this idea of engagement. What does that mean not just in terms of the flow and fuzzing contracting but also decision making. Through out the process I've seen many PPSs and some of our CBO partners now complaining that there are these governance structures that are not meeting again not meeting at all anymore within these PPSs. And some are trying to be dissolved and I think this is telling to us how they value CBOs although they value community engagement. They are now understanding it and that they can understand it. That's why CBOs are there to try to help do that. And so this is a big challenge that we all got to but this idea of metrics are important. The PPSs are also an opportunity together to learn from each of these learning

collaborative as we are aware. Not fully know whats going on in those learning collaborative it'd be nice to know was how these PPSs are sharing information. But the CBO can have a good opportunity at those learning collaborative to be a part of that to discuss what they do and what the challenges are. The other areas as these PPSs have these hotlines are these some calling number for troubleshooting particularly for contracting and so on. But none of that is really talking about it there are challenges around the engagement. What is being going on within the relationship between CBO. So I think is important to have that type of information.

What they are reporting on and what those hotlines can do even more of troubleshooting lines. Finally I just want to say that we just in terms of just the flow of the funds that there is need to be really much better reporting. How that money has been used and being compensated was actually being funded and thats not clear when we read the reports coming from the PPSs. And as well I want to state that in the value based payment roadmap It is also indicative of how there's a lack of understanding of CBO's involvement. I understand the Tier 1 Tier 2 but really CBOs are more complex than that. And do a lot more complex things. And so PPSs may see us as an important in the process but they havent made us important partners in decision making and thats critical in this process moving forward particularly when we have a federal government and the environment that's going on here. CBOs can be better partners but we have to be equal and have fairness in that partnership. Thank you.

Thank you. Yes.

My name is Kevin.

Please.

I am the executive director of an organization called eye health which is 25 community based organizations that are connected by the provision of care management services through the health program and I am also the executive director for the IDUHA IPA which is a newly forming IPA that's in New York City. I'm also the on the steering committee for the communities together for health equity and have been participating in those kinds of conversations since the beginning of DSRIP. On a group of us began meeting in Brooklyn to discuss the the the beginning of DSRIP and how community based organizations can play a role and really that those conversations started out primarily as a as a as a sort of a venting session but they turned into how can community based organizations be good partners in providing health care. And I think that's where we still are today trying to answer that question how can we be good partners. And I think that in many instances in the first couple of years we have maybe missed opportunities to do that. Many of the PPSs or I shouldn't say many at least a couple of the PPSs that we work really closely with have tried very very hard and worked hard to include community based organizations in a very meaningful way and that's greatly appreciated. But I also am aware that others have not. And so I think that we have an opportunity here.

We're close to the midpoint to really look and reflect on the first couple of years and see where we're headed and how we can improve what we've done. So a couple of things that I wanted to bring up on. Coming from an organization that represents a group of Health Home Care Management Agencies it seems to me that although health home health home program is potentially a very critical intervention in DSRIP it could it could impact the outcomes that we're trying to achieve. It hasn't really been treated in that way and where we are today in the health home program is that it has a lot of problems. It's a it's at five years going on six year program and there are a lot of issues in that program program. So DSRIP is an opportunity to help stand that program up and make it strong and use that resource of care management to be able to help impact the outcomes. And I and I don't think that we've done that effectively across the board. Again some OOSs have

and others haven't. So I think we can do more of that. The opportunity is to do more of that. The other the other piece is that community based organizations still do not yet know how they fit into the economy that we're moving into the market that we're moving into value based payments. And I think many of us don't know the answer to that question so it's still it's still an open question but we're trying to answer it. And what are the structures that are going to support community based organizations and how do we build those structures so I mentioned that I'm helping to build an IPA.

And I think that there's real question about how do how do other community based organizations build the structures that they need to be able to participate fully in value based payment as a structure. So I think these are some of the things that I'd like us to be thinking about as we move into this next phase. The last piece I want to mention is that the PPSs are now going to be looked at in terms of their performance and whether or not they've done a good job of setting themselves up in the first couple of years to be able to perform at the at the measures that they have to perform at is a question for ,any I would assume. Actually I know the answer to that is people are some PPSs are worried about that. So I think that there's an again another opportunity for community based organizations to help during this performance phase and to really reflect back on how we've handled the first couple of years and how we could handle the next couple of years and engage community based organizations in a meaningful way so that they can help achieve the things that we're really looking to achieve inside of DSRIP. So that's it. Thanks a lot.

18. And then 19 you could come up please.

Dr. Brown from the Arthur DSRIP for Urban health. And also part of the consortium together for help. I think most of the people from the CBOs have mentioned the list of things that we're concerned about. It's not a first and we're saying it we repeated in each of these settings. And the question remains what are the responses how are these things going to be address. So these processes can become a therapeutic process where we can just exercise our frustration give you a list and complain. So we're hoping that after this process we have some signal that these conversations matters and why I say this because for us we are here because we want this to work, Force is not satisfactory to penalise the PPSs a waiver at the end of the process. We want this to work because a community who is going to be impacted is our community. These are the people will continue to die too soon not have quality care. And that's our concern and that these are public resources that should achieve that. So we we are concerned that the model is about penalizing and punishing at the end. We want to make sure that we don't design a car that cannot move. We want it to move on we want it to take us somewhere else. So within that construct that's what we are presenting these concern now. We think that the mechanism of communication we hope that the state can change a little the way is been the entered the lack of intervention in this process. So for example we are doing the strategic plan as everybody explained before we got it late. It took so long time. Some of the our other areas have not received the money yet. So first question is what is the strategy to integrate it with strategic plan as we complete the process to make sure it's going to impact the outcomes and that it was integrated in some of the metric from a because we were a little first in the design. So we're doing it late so we want to know the mechanism to include us and that we engage with the process to make sure it's understood what we are asking for. I also recommend that just to follow some of the complain of the list in the issues that we set up a mechanism where CBO's and PPS's can have a real conversation to assess our our understanding of where we are today. We continue to be outsiders. We come with five minutes and there's no integrated conversation. The relationship with PPS. Some of them are decent.

Others maintain the pathology of power they design they define and they tell us what to do and what his expectation. Is not. There's not equity in that process. So we are asking for better structure of engagement and that the state provide some leadership to make sure at the end we have some sense that our work is value. And with this we think that the value based payment even there's a

great probably idea is defected because it doesn't include how you value community based organisation work in relation to prevention in relation to continuous care in relation to trusted cultural relationship in their communities. And we're not clear that there is going to be an integrated. So we're asking that you again figure out how you're bringing community engagement to make a difference at the end of the process and not just to fill check the box. Thank you I think you wanted just and again we are here because we're committed for this process to work. We put in a lot of time a lot of effort and we hope that is recognised and it helps to move this process forward. Thank you very much.

Okay.

Are you 19. I'm 19. Not exactly. But I'm 19.

I'm Chris Norwood executive director of health people and also very proudly we're head of the Bronx hub for communities together for health equity. We really appreciate the state grant. It has only made us realize more as we work with our other wonderful CBO's and see what they're doing and what they need to bring forward and haven't had time to bring forward how important this planning grant is and how much it has to be renewed to have us reach our DSRIP goals.

I was very very happy to see that Mr Helgerson recent Whiteford he mentions innovation funds as the innovation that's most important. That is one thing that came out of the community groups. They were the first to push that and we have a lot of other effective ideas that we need more time to bring forward. I would also like to speak about transparency. For example when the AIDS Institute comes to audit our funds. They go through every signature for every Metrocard.

OK.

That's the kind of auditing we have as a community group at a minimum. And this is an enormous amount of public money. We have to have publicly available what each PPS has spent who they've contracted with not just community groups and how much of that has been spent and what it's for. This is all an Excel shee in the PPS's right now and it just needs to be put up in public so we can all begin to understand better where we are. We also need for the community groups. We were not part of the infrastructure Grant. We're grown ups. We need I.T. we will never be a completely effective part of this until we have I.T. for closed peripherals and for tracking patients and their outcomes. I'm just going to give an example of what we have done and health people has at a community level been able under DSRIP to establish what I believe is now the largest community based diabetes self-management program however and we're now advising about 8 groups in Westchester how to get this up and running. But we're still the only group in New York City which has done this and other groups need the time to do this to take the example of what we've done and take it to other PPSs. This morning some of us were at the Crain's diabetes summit.

And of course we got to talk about self-care education and what it really saves not just in terms of money but the literal agony of communities. These rates of amputation by the way one above the knee amputation the first year now costs 150 to $200000 just for the surgery and the prosthetics for the first year. So when you have self education that clearly prevents that.

It is paying for itself. It prevents dialysis, blindness. 19 percent of adults with diabetes already have measurable problems with their eyesight. On the other hand what we heard at the summit this morning is where things are heading. If you can't stop this if you can't get good self-care education. Double transplants, more dialysis, machines that people wear etc. etc.. I can not tell you how expensive aside from being you know just not how you want people to live how expensive this is. And getting the community groups up and running. So not just with diabetes but with other chronic

disease with mental health conditions that they can really in their communities help people get on their feet and be healthy. We know it will save now but as the system becomes more and more mechanized with all these machines for everything it will save more and more.

Thank you.

Thank you. 20 and 21 with 22 and 23 be ready to go please.

20. Good afternoon my name is Violet Armstead. I am one of the peer mentors educators at health people. And what he has done for me has been a prediabetic. My mother died from diabetes. It helped me get into the communities to teach each and all that are diabetics how to self manage in care and prevent amputation. And this program has been going on for some time and I've seen the outcome and how the patients that came to me after we did our program with them and told us that A1C level has been down tremendously even down to my own. So I think these programs these community based organizations should be here all over. All boroughs and is needed. And I would like for you all to please try to help keep these community based organizations in participating and keeping us alive. Thank you.

Hi. So I wanted to start by saying it's just such a good idea to look at the social determinants of health as a critical part of care and even that the value based payment system to me somebody or some group of people totally deserve an atta girl for this.

So could you give us your name please.

Or a comment with it. Yeah Heidi. So but I just wanted to I wanted to caveat that that obviously the nurses and our group in terms of like having CBO work valued more. So my name is Heidi Hines I'm the executive director of the Mary Mitchell family new center which is a little community center county controlled community center in the Bronx. Weere part of the Northwest first meeting clergy coalition's health committee. And we're part of C T H E and I am not nearly as smart as all of the other folks that stood up for CTHE and we agree with them. And Bert we agree with everything that everybody said. I'm not going to even try to repeat it. And so I just wanted to bring up a little bit about the social determinants of health because we have a focus for the past eight years on that at the center and we developed the Social Determinants of Health workshop to help our board and our staff and our youth and the members of our or neighborhood association to really look at the root causes of poor health and and figure out what our priorities for our neighborhood should be. We identified youth violence, lack of access to fresh food, and the need for community based development as the as the things that are most important in our neighborhood. And also we sponsor some housing organizing to help Folks there either have poor conditions or they're trying to prevent eviction. We understood early on how important DSRIP and the Bronx partners for healthy communities really really close to St. Barnabas Hospital.

How important they could be to the work that we're doing. Mary Mitchell has been in partnership with same part of this for the whole 20 years we've been open. I've been there 19 years. They are just good people they have always wanted to be in partnership with us.

And the one thing that they did outside of the work that we're doing is Recently our city council person Rich Torres and the mayor allocated funding for the Cure Violence program in our precinct and in another precinct. And that is just so incredibly important because in our neighborhood kids kill each other with guns. Right. And that you know whether they go to the hospital or it doesn't matter if they're hurting each other that badly so that was super important to our neighborhood.

And they understand the value of the work for doing around social determinants of health. And in

the way we think that the idea that the priority should come from the neighborhood the neighborhoods and the people that live in the Bronx. When St. Barnabas became the lead for the DSRIP we were excited to see how we could build on our partnership and find ways to better address the priorities that we had set. And we're really not been disappointed. From the beginning St. Barnabas showed its true interest in engaging the community by by hiring Amber was here yet because Albert is totally from the neighborhood and so he knew us and he knew the other people the other organizations in the neighborhood. That was a really important decision in my opinion. The r b our PPS has created many committees and workgroups that we and other local organizations can be a part of.

Also from the beginning we were involved in the planning so they the folks that at our PPS did engage us really well I think in creating the committees that they have. We've been able to help them to identify the training needs of our workers to help us develop an online tool that connects us to each other all the nonprofits and providing opportunities for us to take lead roles in innovative health and community projects that serve our neighborhood. Mary Mitchell is one of seven groups that got funded to do community health outreach. And our effort together many of the other folks are in the room here our effort together really did help us to reach people in a new way to talk to them.

Time is almost up.

OK. And I'm almost done. I promise I guess I'm just going to. We got an innovative fund to use food as medicine. So it's a great way to use our law canasta which is our food buying club and connecting with folks with diabetes. And I guess the last thing that I do I just wanted to say is that this effort really does have the possibility of transforming the lives of people in our neighborhood and our families deserve it. And in fact it's really overdue. So that's it.

22 are you 22.

I am 22. Although somebody who I want to hear what I'm saying is just leaving the room.

Will just take a deep breath and wait a second.

Are you 23 and a half there. Why don't we. Do you have written testimony to to put in or. All right we'll wait if you want to take a quick stretch break. Just stand up. Don't leave the room. Just stand up. Can you tell me how many numbers you gave out. Can you tell me how many numbers you gave out. Person with numbers.

Folks reconvene. We gave you a moment. And now you got to come back. So let's start with you.

Thank you for that.

Please respect the speaker.

Thank you.

Great.

Hi there I'm Bonnie Moham the director of the Bronx health and housing consortium. We're a network of health care housing and social service providers in the Bronx. We have all the major hospitals health homes PPSs in our network as well as several managed care plans and a whole array of community based organizations particularly housing providers. So we're really a place

where we try to bring all of these stakeholders together who are serving people at the intersection of health care and housing to improve the way that we work together and to also advocate for this population of people who are homeless and unstabely housed and you know in and out of hospitals the medically homeless we call them.

So we've been doing some work in this area particularly on the MRT supportive housing pilot with our partner Bronx works who is one of the Ann fortune society who got the awards in the Bronx for the pilot units and we've done a study for people one year pre housing and on year post. And we found a 30 percent reduction in Medicaid costs since being housed. And I just want to say that that also includes folks who whose Medicaid spending did not go down because by getting this housing they actually became eligible for care that they could not before that as a transplant. If you don't have stable housing you can't get a transplant. So that was the average savings. And so I just want to encourage this state to consider more investments in Medicaid supportive housing. It's really effective. And then also just the importance of targeting these units, I think some of the earlier units that came online there wasn't a whole lot of coordination with health homes to try to get those folks into the units and they didn't necessarily show the same level of savings we have put a work group together of managed care organizations as well as health homes and housing providers to really look at that data and to come up with best practices around that. I'd be happy to share it. But we had some really impressive results. But one of the things that we found to that is it's really hard to get Medicaid spending information for people.

We looked at it from a lot of different ways the way that we ended up doing it was through individual application to the Medicaid data warehouse which has a three month lag on on data and it takes time to get that. So I think there's this push towards identifying homeless health utilizers which I think is important and we're really advocating for that. We have to make it easier to give folks access to this information housing providers I think are more than willing to give extra attention to these folks. But if they don't know who they are they're not going to be able to do that. We've also been a part of a project with the Corporation for supportive housing in the Bronx Rijo around Bronx frequent utilizers working with managed care plans to get large batched lists of their highest utilizers cross matching it with Department of Homeless service data for you know for homeless histories and trying to prioritize those folks for housing intervention. It took over a year just to get the agreements in place to be able to share that data amongst all of these organizations and respective legal departments. That's just not going to work on a large scale. So just things to think about in terms of getting access to this data and making it more available at the front end. I'm also a partner of the CTAG before I forget. And so really just thinking about how we can better include CBOs. The other big project that we are working on is a medical respite program. We did get money through the innovations funds from BPHC and are working with Bronx works to develop this program.

We have hospitals on board who are interested and willing in purchasing beds for such a program and we also have managed care groups are interested in participating as well but without a specific billing code for this type of service they can't really do that. So I would just encourage the state to start thinking about medical respite as a solution. We did a study also supported by the PPS in the Bronx of folks in hospital inpatient units who were medically cleared for discharge but cannot be because of a housing issue. And we found about 20 people and we did a point in time that that met this criteria and some of them had hundreds of days past their medical discharge date where they were still in the hospital. This just makes no sense for anybody. And medical respite is a really good solution to that as a place where people can step down from the hospital when they still need a little bit of ongoing care but are not able to go either to a shelter. Back to the street if that's where they are living or even sometimes with families who are just kind of tired of taking care of them. So we really encourage you all to think about medical respite as a solution and think through ways to make that more accessible particularly through through building codes on Medicaid. Thank you.

23 and 24 if you could come up.

Hello we wanted to thank everyone for this forum to speak as well. My name is Benjamin Lu. I'm a medical student here at Medical Mt Sinai and I am also part of the East Harlem health outreach committee and we want to read a statement that we provided here. Just a brief background found in 1976 East Harlem health community health committee's mission is to improve the health status of East Harlem. The HHCC is deeply concerned by several aspects of how the DSRIP program is being implemented. There are documented problems with DSRIP across New York State and EHCEC is particularly concerned with performing provider systems located in our neighborhood MT Sinai PPS and the one city health PPS as well. Given that one missions of the DSRIPs remote community level collaboration and system reform. It is hard to understand why funding distributions statewide skew heavily toward PPS Project management offices and away from communities. For example the Mt. Sinai PPS project management management office received 66 percent of funds distributed by the PPS across its network and one city health PPS product management office received 67 percent of funds. While only the community based organizations received point 9 8 percent less than 1 percent in both. Right. If DSRIP has any hope of meeting its goal of reducing unnecessary hospitalizations by 25 percent over five years patients must receive preventative and curative care in the community not at the PMO. And as a previous speaker had already mentioned the Robert Johnson Foundation has a study that mentions that 80 percent of health care is in the community.

If the community is only receiving 1 percent of the funds the math doesn't really add up. This data shows that PPSs are taking advantage of DSRIP to ask more of their community partners without providing their support of reimbursement. Community partners are expected to increase caseload design new programs hiring new staff and are simultaneously given little funding or support to accomplish these goals. Through March 2017 Mt. Sinai PPS dispersed five thousand nine hundred and ninety five. Five hundred thousand ninety two dollars and reported engagement with 122 to Tier 1 CBOs. A rudimentary calculation shows that on average each of the CBO only received four thousand eight hundred dollars. Over the course of two years. Significantly less than needed for any sustainable changes while engagement numbers are also inflated by double counting little projects from the same CBO organization. It is clear that simple quote unquote engagement needs to be matched with financial accountability. It is evident at the lack of CBO stakeholder inclusion has also led to some of the confusion and frustration of the DSRIP process. CBO's need funding not the entirety of the DSRIP process to effectively collaborate with PPS organizations. An earlier CBO input into the funding and management mechanisms could have resolved this issue. Even as DSRIP passes the year three the needs to be more effort from PPS organizations and the New York State Department of Health to involve CBOs in their governance structures and enhance transparency in contracting between CBOs and PBS.

Thank you.

Hello my name Siramny Bathok I'm also first year medical student at Mt. Sinai and I'm also part of each EHCEC. To continue off of what Ben just said. In addition to inequitable compensation levels most people in Manhattan have only provided funding to a few tier 1 CBO's to implement an implementation phase of DSRIP. Recruitment of more tier 1 CBOs is necessary to support their roles in providing care to avoid hospitalizations and extending outreach to under-served populations. Although CBOs and PPSs have different funding sources and thus different financial incentives to provide services it is imperative that they agree upon a set financial plan that combines their different strategies towards contracting services. Furthermore the funding that PPS organizations have currently received through DSRIP comes from meeting reporting metrics. However in the future PPS organizations will be granted greater funding for performance than for

reporting metrics. It is important for PPS organizations to have a stronger collaboration with CBOs in order to attain payments based on performance in the future. In the past year the New York State Department of Health has evaluated PPS organizations and their relationship with CBOs in a midpoint assessment. The most common recommendations were quote The PPS must develop a detailed plan for engaging partners across all projects and the plan must outline a detailed timeline for meaningful engagement. The plan must also include a description of how the PPS will flow funds to partners so as to ensure success and DSRIP.

Your time is almost up if you could wrap it up.

No problem. The goals of DSRIP require the hospitals and communities work together in partnership and even after three years this is still not going to accomplish.

Indeed the ECHC fears that the DSRIP will wind up nothing more than an $8 billion giveaway to hospitals and health systems or community organizations and the communities they serve who are left in the dark. While continued reports from New York SDOH might suggest all has gone well with DSRIP those on the ground east Harlem know that this is not true. They also know that the only way for DSRIP to succeed is for funding resources and true partnership to be offered to communities moving forward. The EHCHC hopes that stronger efforts are made to ensure the positive results of this DSRIP will actually be seen in the communities that purportedly helps rather than solely as a partnership's paper.

Thank you very much.

OK. My name is Alan Crosby. Thank you for your grant. I'm a peer from Heath People. You heard from a couple of my peers OK. I'm with prefer to help people for taking from from my long table. It's important for me to say that so I would prefer to help people from a drug program so I want to help people and I didn't know I was there for like selfish reasons. I won't go there to the drug program and just leave.

But and I did that. But help people helped me in so many ways. I got. They helped me with affordable housing they help me get the felony off my record. And they helped me change my whole frame of mind. Thanks to people like Chris Norwood that worked so tiredly and helping people in the community change their life. And that was the most important thing that happened to me while withhelp people. It helped me change my whole frame of mind to want to help people because when I work with my peers my coach peers. It me to want to help people into my community. I want to teach people to help themselves/ Thats what we do help people. We teach people to love out and we teach people to go out there and love your community and that's one of your oldest lessons that you need to learn here in this world. So they taught me a whole they helped me with so many things to help people. And I see them in the building to help little children with family needs, they help people with HIV, they help people with all kinds of chronic illnesses. I had a stroke. I couldn't walk. I couldn't talk. When I first came to help peopleI wouldn't dream of talking to you people like this. I couldn't protect my voice. I'm walking away from the mike because when I got my words back I'm going to talk.

So please continue to give back the grant. Health people it's not just a place about chronic illnesses. It's a place about love. They teach you how to love. I see these people come at work so tiredlesslyand they start to take that to what they do and they don't get paid for this. They do this from day. Love what they do. They love to help people and that's what gets me because I had a stroke I couldn't move I couldn't walk. And I get up in the morning at night aches and pains but I get up in the morning just ready to go and be with them because I see the way that they are. I see what they want to do and you want to be a part of something that's higher yourself. It just gives you

some kind of energy and makes you want to get up and do what you have to do to help other people. So please keep on giving up these grants today. Because what you did by giving that money helped a person like me. And your money helped a person like me.

Thank you very much.

Yeah.

Yes. We have 24 and 25. Oh OK we're both 25 and 26. You;re 26 and 27 is at 27 here. Come on now. Go ahead.

Good afternoon. My name is Steven Pappas. I'm the director of development for meals on wheels of Rockland County. Were a Tier 1 CBO. In terms of our services we do average home delivered meals as everyone knows but we have about five hundred clients on home delivered meals. In terms of our other programs we also have five senior activity centers throughout the county where we serve over 500 older adults. We also have an adult daycare center where we service individuals with Alzheimer's disease and dementia and not applicable to this but we do an Adult Learning Center where we teach older adults different technology skills as well. In terms of being a tier 1 CBO. We're partnering with Montefiore Hudson Valley collaborative where we're actually really excited to be partnering with them. They bring the medical expertise where we're not a medical model in any of our programs. And in terms of where we are with them at the moment we have a $20000 planning grant with them where we're partnering on a program where we're going to have their trainee training come in and train our staff our volunteers how to see different indicators for our home delivered meal clients and for our senior activity center clients. Because I'll tell you many of our volunteers they may go deliver a home delivered meal and every single one of our volunteers has an instance where they find one of our seniors on the floor from heart attack stroke whatever the case may be. And it's heartbreaking for them. They wish they could have done something in advance. And thankfully you know with the partnership with Montefiore that's what we want to do.

We want to try to give that expertise to our volunteers and to our staff members so that in advance we can see those different indicators have that training for them and provide that help to our older adult population. Now in terms of the process where we are moving forward with them is that we did a survey pre-allocation in their innovation fund where we surveyed about a hundred and seventy six of our clients out of the almost 11 hundred clients that we have in our older adult population. And out of the 176 50 individuals already responded in the last six months they'd been to a hospital. So our aim is to try to reduce that number in our Medicaid population by doing this proactively and preventively. In terms of what we're working with on the planning grant now is to figure out the different partners. We do have a social work department where we do referrals out but that's only if a client comes to us and says you know what my doctor said to me that I have some issues with my sugar levels. I really need some help with managing that and then we'll do a referral out from our social work department. But for us to work with Montefiore and to be able to move that forward and identify a small cohort that we can manage and actually move forward in making a real difference in their lives so they're not high utilizers down the road in our emergency departments then that would be great for our agency. And that's where we're looking to do.

And one of the other partners that they're trying to we're trying to collaborate with is Nyack Hospital which is one of two of the major hospitals with in our county which is a partner with Montefiore. And just to wrap up we're just really thrilled to ass the CBO we don't have as I mentioned that medical expertise so to have that kind of partnership with Montefiore is very thrilling to us. Thank you.

27 20.

Hi my name is Deanna DoBear I work for Courtney behavioral care. Good afternoon and thank you for the opportunity to be here today to talk about our partnership with the Staten Island PPS and the impact this has made on the community based services we deliver on Staten Island. Coordinator behavioral care is the lead health home on Staten Island and delivers other care coordination services through five care management agencies including Jewish Board, Staten Island mental health society, Statent Island behavioral network, project hospitality and community health action of Staten Island. These agencies all have a strong footprint on Staten Island but prior to partnering with the Staten Island PPS many of them worked in silos with other community based medical and behavioral health providers on the islands. This is no longer the case and the collaboration with the PPS has strengthened the partnerships and linkages across the island and service delivery providers. Through partnership with the Staten Island PPS. Our CMAs now have a breath of access to resources and relationships that affect the health outcomes of the communities we serve. Through the health home at risk project branded as SI cares community at risk engagement services.

CBC is working with the staten island PPS to coordinate and deliver community based health care to Medicaid recipients. Working with these five care management agencies. The CBC SI cares network has served over 2700 Medicaid recipients since launching in 2016. Staten Island cares provide a short term health focus care ordination service for Medicaid recipients dealing with chronic health conditions most of whom struggle on a daily basis to address their most basic health and social service needs. Our network of 30 plus health coaches through these five CMAs provide light touch services that help community members connect with information and referrals advocacy and support the community support services. Staten Island cares teams hope community members to enhance access to primary care services address their social factors that inhibit their health and provide overall preventative support service to reduce unnecessary hospitalizations. Aligns with DSRIP goals. Staten Island care's main goal is to prevent unnecessary hospitalizations by educating and informing the community about resources and helping with community support. For many of the Staten Island cares clients the community services that health coaches provide also enhances their self-sufficiency and self advocacy through access to crucial safety net supports. Working with the Staten Island PPS has meant that our network of health coaches receives up to date and relevant training and supports that enable them to provide the highest quality of care in the community. Through the PPS CBC's relationships with Richmond University Medical Center and Staten Island University Hospital has strengthened allowing for a more seamless handoff to care coordination services from these hospitals. This is critical and we're seeing that more people than ever are being discharged with community services already in place thus leading to fewer hospitalizations.

With the PPS. The high level of coordination and management allows CDC and CMAs to focus on the most pressing needs of these individuals. For the first time conversations with community based providers and medical providers are happening at the same table. Through the PPS we are no longer just focusing on social needs or health needs. We are now working collaboratively to ensure that the most vulnerable individuals stay healthy and access vital services in the community. Thank you for your time.

28.

Thank you for this opportunity. My name is Ami Cree I'm the executive director for Hudson Valley care coalition were a health home that covers six counties in the Hudson Valley area. We have relationships both with W.M. WMC PPS and Montefiore Hudson Valley collaborative PPS. And a colleague previously said that it's very very important for the PPSs on the health homes to work together and to work collaboratively and I have to say that both of the PPS of the WMC and Montefiore worked with us to help us address outreach strategies and create more innovative outreach strategies. While the PPS each PPS took a different strategy. WMC they worked with our

CMA's directly and our care manager our care managers health care managers are embedded in hospitals across the Hudson Valley and embedded in physician practices across Hudson Valley in order to catch the people that would who actually really need health home services. Montefiore just recently granted HVCC an innovation fund and we're partnering with Cherian community which is a shelter in Yonkers. And what we're trying to do is figure out what are those strategies to engage with homeless and the disengaged members of our community and get them the services that they need and not only medical services but other kinds of services. And not only health home services. So with these relationships I think that I was a little bit nervous when I took this job about a year and a half ago because we are one of the few health homes standalone health homes.

And what I mean by that is that we're a coalition of agencies so we have hospitals we have CBOE and our network and we have federally qualified health centers but we're not connected to a hospital. Right. And so we don't know how that relationship was going to pan out. And both WMC and Montefiore reached out to HVC and our CMA to make sure that we build a strong partnership and addressing and working together to get the Medicaid population the services that they need.

Thank you.

Good afternoon. First thank you for the forum. My name is Tascha Chilen and I'm the director of programs at the Bronx community health network in short BCHN. BCHN is a not for profit community based organization and a federally funded health center. We promote disease prevention early treatment and healthy lifestyles for individuals and medically under served areas. BCHN signature community health and wellness program aims to improve the overall health and wellness of the bronx community at large. We target medically underserved neighborhoods where socioeconomic issues such as substandard housing high unemployment or unemployment food insecurity lack of health insurance and legal needs commonly affect their ability to manage their health. BCHN serves as a hub that recruits trains and deploys caring and competent community health workers throughout the BCHN health centers and in various communities settings. To serve as a bridge between the patient client population and the clinical and social service providers. At the health centers our CHW program offers integrated community based services into patient centered medical homes and provide coordinated care to patients with complex and unmet needs. In community settings our CHWs and patient navigators conduct outreach activities to educate and promote healthy lifestyles provide home based support assist within your state marketplace enrollment facilitate health screenings and address the social determinants of health needs to linkages to community resources. In an emergency department our emergency department later on identify patients who present with no health insurance coverage or who are seeking care for non emergency reasons and connect them to a health center to receive continuous affordable quality care. The program serves to reduce the burden on an overload overloaded and misused emergency room system.

Joining BPSC has given us an opportunity to collaborate with partners on this DSRIP. Mobilize our resources and work towards a shared goal that is positive and measurable. This is one of the BPHCs 7 community health literacy program partners working to educate the community excuse me on health insurance and on and on how to navigate the health care system as well as to connect them to health insurance local primary care providers and other services. As a community health literacy partner. We have been able to expand our outreach efforts within our communities. We also have been able to tap into our network of 200 community partners to provide education and technical assistance on the health care system. Health insurance and affordable care act the application process. The feedback from the community has been overwhelmingly positive and we have been proud. We are proud to reach more than sixteen hundred community members between December 2016 and October 2017. BCHN is also a member of community engagement work group and work for Sub-Committee. And has and has had a rewarding experience working together with local

partners to assess and find common areas around our patients and clients needs and a certain the training needs among our staff. One of the outcomes from these ongoing meetings is the development of development of an online resource directory that is designed to connect us to each other and the brox community members and also as a result of the feedback from the community engagement group BPIC offered several trainings for CBO.

Our outreach workers such as community health workers and patient navigators have benefited from these some of these training specifically the 60 hours of care coordination training cultural competence and training and legal referral training going forward. Clearly there is a need for more funding opportunities for community based organizations. And to be more specific more grant opportunities for CBOs and some sustainable value based payment opportunities for CBO to partner with providers to provide care coordination services to patients who have complex and high unmet needs. And sure in a cost effective way using community health workers studies. Again multiple studies have consistently shown that such model can improve both the health outcomes as well as save lives. Thank you.

I'm 31. .

OK. Good afternoon my name is Heidi. I'm a peer coach for health people.

Good afternoon. My name is Heidi. I'm a peer coach leader for health people for diabetes. I am a diabetic and I started out taking the pre-diabetic class and I was already a diabetic so I learned so much from a back class. I was a participant. I learnt a lot and that made me become a peer coach leader for diabetes and I am a legend living legend because I'm standing right here right now. I lost over 15 pounds. And I kept it off for over a year and a half and I cut a lot of things out of my diet. Lots of Soda. I stopped drinking soda. I stopped eating ice cream. And I did a lot of things smart. And I I helped people along the way that we give these workshops for and they know how important it is because they call us back to come back to the site to give workshops and we do multiple workshops. You know in the week and they do appreciate us and we work very hard in different kind of weathers. And we are so grateful we call ourselves Crusaders OK we're strong and we want to live long.

You know we teach them how to go to the doctors you know it's just like when you have a car you know you got to tune up your car and you got to you know check your car for different things. It's just like your body. You got to check your body for different things you've got to go to the doctor. You got to stand up you've got to be your own advocate. OK so we're going to try. We'll teach them how to live long and be strong. OK.

Thank you yes. Good afternoon to the panel.

Good afternoon Steven. My name is Dr. Bertillon Marcus. I'm the community director for the borough of Brooklyn on a community advocate and development. It's great to speak before you again. I go on Bernstein. You know I just want to put a spin on on this discussion here because it's vital it's a vital need for health care in our communities especially Brooklyn central Brooklyn and east Brooklyn. We have three hospitals in in in this vicinity that are in Crisis. And because of the lack of knowledge and lack of disrespect for our community we are faced with a crisis of closure. Now they just implement the one Brooklyn health care for for central central and south Brooklyn. Now we also have Wyckoff hospital in northern Brooklyn northeast Brooklyn that's also in crisis. And we have so much money that's being disseminated elsewhere out of the way it's supposed to be. Now I've been fighting for many years as you know Steve for many years especially when they were closed in the St. Mary's. And I said to myself that I will no longer sit by with all this knowledge and expertise and allow the state to close hospitals especially the ones that are needed in

our communities. Now I said as the state representative from Cuomos office why margin of these hospitals will not work. And I send them a letter I spoke to them directly and they say oh we can be taken into consideration they brought in Northwell to do a study that we've already done.

As you know we've done many studies within this catchment area of health care and and Northwell they say oh no Northwell was only going to do a study and we before Northwell came in. Our Assemblywoman went up and actually buillied the governor for money to come to the hospital which is 700 million now he was asking for more. And then all of a sudden the $700 start getting depleted because they're bringing in urgent care centers which I think has about 35 dimension and our facilities to take up the money that's supposed to help these hospitals strive and become better. There's a lot of things need to be done. And if we are to focus on health care and helping our communities we have to make sure that these are adequately and affordable truly affordable housing for our community residents. Because right now the communities are below the poverty level and at the rate that they are renting people it's outrageous. It's a crime that's being committed and we have to address that maybe on on another Panel. But right now we focus in on health care and keeping our institution viable and functional. There's a lot of things needed in these hospitals to make them vital. And if we remove the funding that they get in right now that they are supposed to be getting right now then these hospitals will close no ifs ands or buts. They could call it one Brooklyn and all what they want to name it. But we need the funding that we need to stop the excess overspending elsewhere and put the money where it belongs so that these hospitals could could strike.

We don't need to merge any hospitals because one they remove the maternity care at some of these hospitals and they are less than some of them. And those are services that will definitely help these hospitals to strive help these hospitals. We need funding the funding for the federal government sent a lot of money down to this state. And still I'm asking where did the money where did that money go. We need that money to be allocated to these hospitals so that they can function well and half of the COs and CBOs and CFOs and whatnot that's making these high prices let's start cutting a pace because they walking around the hospitals doing absolutely nothing for.

Your time is just about up so.

I just want to I just want to say take this to know I would die first before I let any. Let the next hospital close in our communities because if a hospital close it will devastate the community at large including the small businesses that that are striving for the benefit of the hospitals. Thank you.

33.

I think 32 is coming back in. I''ll get started. Thank you for the opportunity to testify. My name is Max Hadder. I'm the senior health policy manager at the New York Immigration Coalition. We are a statewide policy and advocacy organization with over 200 member groups representing the collective interests of New York's diverse immigrant communities. And our health policy and advocacy work. This includes monitoring DSRIP to ensure that New York's delivery system reform is responsive to the states over 4 million immigrants. We sit on the one city health performing provider system executive and patient and stakeholder engagement committees. We've convened partners from across the state to discuss the experience of community based and immigrant serving organizations in DSRIP and we're a member of a statewide advocacy group. Medicaid matters as well as communities together for health equity. A coalition created organized CBOs to have a voice in DSRIP implementation. Two promising initiatives the strategic planning grants and innovation funds have improved the prospects of CBOs participation in DSRIP of late. However the amount of ground to cover is still formidable in the race against time is not favorable given that CBOs are only now beginning to receive the assistance they were denied at the beginning of the program. As contracting becomes more complex in the move toward value based payment DOH and the PAOP

together with CBOs need to continually propose mechanisms that balance the an even playing field CBOs currently face in negotiating their engagement with PPSs. To start the DOH should consider a more aggressive oversight role for itself that includes an explicit acknowledgement of the time lost on CBO engagement and a commensurate increase in the requirement for PPSs. To contract with CBO on terms favorable to the CBO. This can take on many forms including increasing the range of social determinants of health that CBO may be contracted to address including immigration status itself. We've heard from several members and partners who provide services to immigrant communities that the current contracting process does not provide them the information they need to make informed decisions about whether their DSRIP work is financially sustainable. In some cases they've declined to participate because the proposed structure for contracting with PPSs would not have supported the cost of participating in the project. If CBOs are asked to provide a service which they do not currently have a source of revenue and the DSRIP center does not fully cover the cost of a service participation in DSRIP may jeopardize the financial well-being of the organization. If CBOs can't participate with confidence and PPSs the promise of value based payment addressing Social Determinants of Health will not be fully realized. This is particularly concerning as the balance of metrics shifts from process to performance in DSRIPs final years. Our partners across New York state regularly report dire language access concerns DSRIPs a sensible programmatic focus on cultural competence should mitigate these problems by incentivizing PBS participate participants to ensure that each patient has access to a culturally responsive care including appropriate interpretation and translation services. The reality is that some PPSs are being credited with cultural competence compliance through woefully inadequate trainings that make a mockery of the concepts of language access and cultural awareness and humility. In the case of at least one PPS It appears that cultural competence training may be limited to one 15 minute video.

One of the roots of this problem is that cultural competence hasn't been significantly defined in the DSRIPcontext to go beyond rote simplistic conceptions that fall short of what it means to be truly responsive to communities and to meet patients where they are. This is a missed opportunity and will be detrimental to the DSRIP enterprise unless it is corrected and the cultural competence screws are tightened on PPSs in the final years of the program. I offer the NY C as a source resource to PPS statewide who are interested in building better partnerships with CBOs to improve cultural responsiveness and humility in addition to competence. At the PAOP meeting on January 30 1st of this year I testified about the harrowing times that immigrant New Yorkers faced under the 10 day old Trump administration. We're now 10 months into that administration and the challenges that immigrants face are at least as bad as we expected earlier in the year. In this environment in which immigrants are demonized scapegoated and dehumanize the already difficult challenge of encouraging ostracize members of society to use needed health services has become a much more urgent and difficult task.

Just so you know you have one minute.

Immigrant communities are willing to trust the dwindling pool of resources that are comprised almost entirely of familiar CBOs and service providers in their neighborhoods. Only by empowering and compensating trusted CBOs can these organizations and the communities they serve participate meaningfully in DSRIP and ensure the engagement of immigrant New Yorkers and this can only happen by increasing the value placed on the work of these organizations to address the many social determinants of health that affect their immigrant constituents in the dark days that lie ahead.

Thank you very much.

Next Anne Monroe are cochair had to leave. Next up is our number thirty two.

OK. And then after that it's 30.

Good afternoon. My name is Debra Lafane saying I represent the Caribbean Women's Health Association and we're located in Brooklyn. So I just want to say that at the beginning of DSRIP I was very encouraged and excited about the possibilities of what the health system could become. My enthusiasm has diminished somewhat but I'm still hopeful. And I stand here to say again that the community based organizations are invested in this process and we offer our assistance in terms of making sure that this works because it's our communities that will lose in the end if it doesn't work. I've been in this business for a long time and I feel like this might be my last chance to be able to make a difference. So I really want to see DSRIP work and value based payment whatever that is to make sure that our communities in the end are well served. I have a few concerns that I'm going to bring to your attention. The first has to do with the transparency in terms of how the PPSs are operating. We are concerned and I speak for CTHE about the numbers of community based organizations that are being reported as partners.

How many of those organizations actually have contracts. And if there is a contract. How much of that contract is actually being paid to the community based organization. I'm concerned about the definition of cultural competency and how this being played out on the PPS level. As Max just mentioned so many of us are working in immigrant communities. And our definition and our knowledge about cultural sensitivity doesn't seem to be reaching the PPS level. We have experience in working in these communities. We offer you our experience and knowledge. We're here to help with this process.

I have four points. I think that in terms of transparency that PPSit's very important that we are able to see information and understand the information so that we can be able to help with the process. And then most importantly I am part of CTHE we did advocate for funding for strategic planning for CBOs and we are working diligently to make sure at the end of this process there is there are recommendations of the strategic plan for the Department of Health. But I think we are going to need more time and hopefully there could be additional funding so that we can continue our work and at the end of the process we will be able to give you valuable recommendations.

Thank you for your time.

34 and is there anyone with 35.

Good afternoon to the distinguished panel and other members in the audience. My name is Joanna Gregory. And thank you for the opportunity to testify. I'm a registered nurse and I work at interfaith medical center in central Brooklyn. And I'm an immigrant from Jamaica and I live in East Flatbush So I'm very familiar with social determinants and how it can impact health. I was very enthusiastic when I was asked to be a part of the DSRIP initiative at interfaith Medical Center. And in fact I was the first nurse that was hired as a transitional care nurse at interfaith Medical Center. That gave me the opportunity to actually see what's going on in this group and care transitions we needed at our facility a robust and efficient I.T. system to help us to coordinate care care management activities care condition and patient engagement and outreach and monitoring. I'm not sure if anyone is familiar with the max project that started at our institution before we started the second phase of DSRIP and what came out of the Marx project was that there was a lot of problems with the homeless population to the outreach. I'm not sure where we are or with that. As we look around in our communities it's been gentrified where a lot of housing that's going up and where I live on my block right across the street from me there is a brand new building that's there for mentally challenged people or a high functioning. But there are like not one bed room to step down from that like a studio. Yeah. So.

I would like to find ask bring to this panel if there is anything in the pipeline coming down to really assist homeless population. Also currently they want us to integrate behavioral health at interfaith with psychiatry and we have been sanctioned because it's not done in the timeframe that its supposed to be done on the PPS plan. And they're saying that we're not making meeting our deliverables.

I think what they could do is to assist us if they see that we're struggling to help push to get things onboard instead of cutting money because we need we need those funds for these patients. And I personally as a nurse I've seen it as impacted patients live and I listen to the speaker before we spoke about how he changed his life around and so on. And I'm doing the same. And we're all doing the same at interfaith. So I would like to touch again even though the point has been stated many times about the transparency of what the budget. We feel that we need to have more transparency to better help our community. And finally what I want to say is that we are also experiencing in terms of human resources we need more people to help us to do these outreach because sometimes I'm calling a patient I feel like I should be in that home talking to the patients. I see a huge deficit there. So I don't know where as the volume in terms of what we're doing gets bigger and the value is also being going to be credited to what we're doing. We need the resources in terms of administrative and human resources to help us to be successful. And this initiative and I think is great because I went to Cuba and I see what you're doing there. But for it to work we need to align all the systems the patients that come into organization the PPS doctors veryone should be on board for this to be successful. So thank you very much.

So I think that's it. I think we've had all of our registered speakers. I want to thank everyone for coming today and on behalf of Renew the CBO plan grant please. And thank everybody for taking time out of their busy day today. Want to thank the panel for being here today and look forward to reengaging with the PAOP in February. So thank you very much.

I would like to first thank the people who testified because it's great. Really good information. I do think because I know I have testified and then walk away I'm not afraid. I would like to know are there some way that we can be responding to people who spent their time who came out and talkedwith us and shared. And where there are responses and there were things that we could be sharing with them.

Sure absolutely. So what we'll do is we've be taking notes throughout. Obviously it's been recorded. So what we'll do is we'll try to take some notes and then send those out to PAOP members to make sure that we captured it and think about the next steps in terms of moving forward.

And send it out to the participants as well.

Yes I think we do. Do we have their e-mail addresses I'm not sure if we do that.

We did. When they signed in. So we got their emails. Then we can send it out make sure that we captured it.

Thank you.

Thanks very much.