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VIRTUAL PUBLIC MEETING

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MEETING TRANSCRIPT

Ann Monroe My name is Ann Monroe, and I'm one of the members of the dual committee, Health Planning and Public Health. And my colleagues, Jo Boufford and John Rugge chaired the meetings that we had last week and so I'll be moderating this session. And before we start, I just want to mention we want to spend lots, have lots of time for Q&A, so please use the chat function to indicate that you have a question and I will call on you in the order that you appear on that chat function. Last week, our sessions related to primary care and public health. And the theme through both of those sessions or all three of those sessions was that in order to be effective in the future, we need more collaboration, coordination, looking at new ways to integrate care across a broader spectrum. Everyone on those panels indicated that one of the barriers to moving forward for them was this sense of isolation from the larger system. So today we're really fortunate to have three presentations by organizations that have really taken the lead in looking at different ways to integrate and coordinate health care. First, we'll hear from the North Country Innovation Pilot, which is a more rural, obviously North country effort to integrate across the care spectrum. And we'll hear from Eric Burton, who is the CEO of the Adirondack Health Institute. And Karen Lee, the ACO, Karen, I'm sorry, what's the official name of the ACO?

Karen Lee Adirondacks ACO.

Ann Monroe Thank you, Adirondacks ACO. And as you know, one of our colleagues, John Rugge, has been very active in this initiative. So if he asked me to keep him on mute so he doesn't take over the conversation. But I do want to invite you, John, when we talk about this project to add your perspective.

Ann Monroe Next, we're going to hear from Maimonides and the Brooklyn Community's collaborative. And that's an effort that grew out primarily from the disrupt world and is a linkage between the Maimonides system and all of its parts and the community in Brooklyn. And David Cohen from Maimonides and Maurice Reid from the Brooklyn Communities Collaborative. We'll talk about what that collaborative looks like and how they see it benefiting clients and patients. And then lastly, we'll see a little different integrative model, which is a health plan, a payer and a medical group. And so we're fortunate to have Karen Ignagni from Emblem Health and Navarra Rodriguez from Advantage Care Physicians to talk about how that collaborative came about and how they see that benefiting their clients and patients beyond the members of the health plan across the community.

Ann Monroe What we've asked them to do today, rather than go one, two, three, four, five on the questions that we've listed, we've asked them to weave those questions into their story. How did they get started? Why did they get started? What need did they see in the community that wasn't being met that needed to be met by a broader, more collaborative approach? We can't ignore the impact of COVID, on these kinds of collaboratives. Did it

advance your work? Did it hurt your work? What lessons did you learn from COVID that are important as you move forward? What kind of barriers are you facing? Regulatory barriers, cultural barriers? You know, we've been in silos for a long time. And what we're now asking people to do is to leave those silos behind and work collaboratively. What barriers have you met? Regulatory, institutional within your collaborating organizations and as I said, culturally. How would you suggest they be overcome? What do you recommend, as we want to move more integrated care across the state. And then lastly, in their story, what's really needed and who needs to be the actors in making this more sustainable, more widespread and more effective. So who needs to be brought to the party that might not be at the party? What's the role of the state in both its regulatory and structural perspectives that need to be included to make this work? So we've asked each of them. We have two hours together today and we've asked each of them to spend about fifteen to twenty minutes between the two of them talking about their story and taking us through how they began, what they're facing, what they need and why they think this is important. And then we're going to open it up. There might be a couple of questions that I might have for each of them or ask them to discuss with each other. And then we're going to keep a significant amount of time for dialogue and Q&A with members of the council. So, please, when you think of a question for one or another of the groups, please enter it into chat so that we can have the full range of your questions, concerns and ideas. So with that, unless John or Jo, you have anything to add that we need to add there, I'm going to open up the session.

Ann Monroe John, you're off mute. What did you want to add?

John Ruge No, not at all. Thank you very much.

Ann Monroe Okay, all right. Well, we're going to start, as I said, with Eric Burton and Karen Lee from the North Country.

Ann Monroe And Eric, I assume you and Karen have figured out how you're going to do this dance.

Ann Monroe So I'm going to turn it over to you and I'll give you a high sign in fifteen minutes, how's that?

Eric Burton Okay, thank you. Thank you, Ann, I'm just testing. Am I off mute?

Ann Monroe You're off mute. And everyone else, please mute yourself. Karen, please take yourself off, Karen Lee, take yourself off mute.

Ann Monroe And the rest of us will go on mute and will, I'll give you a high sign in fifteen minutes. Okay?

Karen Lee That's great. Thanks.

Eric Burton Okay, thank you, Ann. Can you hear me okay?

Eric Burton Again, thank you for inviting us to the panel. We welcome the opportunity to present to the panel here today and take any lead. We'll walk through the story of the North country and start with some background and then kind of weave it into some, you know, real life examples of where we are today. So let me start with the what, you know, what is the North Country Innovation Pilot? And, you know, we all need more acronyms in

health care, so the NCIP in our world. So we look at the NCIP, as unique collaboration of providers and community members working together to improve the health of the residents of the North country, assuring access to care and promoting health. And to kind of start off with some of the COVID impact and we will circle back on this. You know, we look at COVID has only accelerated the need for providers to come together in an integrated manner. And I'll give you one perfect example of that. For well over three months now, we've had a weekly touch point with the regional chief medical officers, just giving them a half hour forum each week to talk about the COVID pandemic and specifically testing strategies and what they're experiencing in their local communities. And it's just been a great example of open communication through the pandemic and in ensuring that providers come together and talk about things like that over the wide geography in the North country. And so before we get more into into the NCIP itself, back up a little bit on history of the North country. So, you know, we look at that the North country as having a spirit of collaboration. From the perspective of AHI, AHI has been in existence since 1987 in various forms, starting out as the Rural Health Network and then the Upper Hudson Primary Care Consortium. And kind of serving as the glue in regional collaboration efforts to establish different unique health care delivery models. Most folks are probably aware that AHI, you know, was one of the direct PPS's, but we're more than that. And, you know, we existed prior to this report. We've missed a long history of grant based programs that help support the delivery of health care across the North country. So examples of those being, you know, we were a PIP. We continue to be a real health network for the ARHN. We have an advancing tobacco free communities grant. We are lead health home agency and we have an enrollment services grant. So, again, a long history of grant based programs supporting the delivery of care. In more recent history in 2007, to our her supplanting planning grant that resulted in the Adirondack Medical Home pilot. It was really an initiative transforming primary care and moving many practices towards the NCQA, a certification. From that in 2013, the Adirondacks ACO was established. In 2014, under the Desert program through the Governors Initiative, IHI, again was one of the district designed to fundamentally restructure the Medicaid program. As we roll into 2017, the ACO began negotiations with the risk agreements with commercial payers and Karen will touch on those in more detail later. In 2018, the ACO began some two sided risk arrangements. And then in 2019, after about six months of more informal discussions about fifteen regional partners, including primary care through the large FQHC headwaters, several acute care providers, behavior, health, substance abuse, the regional PPS and the regional ACO executed MOU, memorandum of understanding to commit to plan toward this North Country Innovation Pilot. So we signed those in 2019. From that, we also spun up four different work groups, including a payment workgroup, a care delivery workgroup, an HIP workgroup and a governance workgroup to really dive into the development of this NCIP model. And one of the more recent activities in 2020, we recently the region was awarded through CBPH a HERSA care coordination grant, which really came out of the care delivery workgroup. So another example of the spirit of collaboration across the North country and that's important to understand as we talked about the NCIP. As we look at some of the why behind the NCIP, you look at the North country represents about sixteen percent of the landmass in the state, but only one point six percent of the population. So a true definition of rural health care. And, you know, we've used examples in the past. You can take the state of Massachusetts. You can take many of the the National Parks and lump them together and dropped them in the geography of the Adirondack Park to give you a sense of of the geography for the North country. So, you know, access is clearly an issue for the North Country. Challenge and recruitment of staff providers to support staff. It's clearly a wide geographic area. Some equity issues in the North country. The region is poor. Franklin County is one example with a twenty percent poverty rate, the third highest in the state of New York. We have, you

know, a less educated region. Higher rates of smoking and obesity and I'll touch on some of those in a moment. And all that just illustrates the real importance of integration to ensure access to care across the region. So for some additional kind of demographics on the North country, the North country is older and sicker than than many other communities in the state and the country and forecast to become even more so over the next ten years. So, again, more the why are we coming together and we'll give you a couple examples of those. Thirty eight percent higher obesity rates in adults than the New York state average. Twenty two percent more likely to be hospitalized for a mental health illness than other residents in New York State. And sixty-seven percent higher rates of adult smokers in the North country. So, again, some examples of some of the help from aspects in the North country. As far as illustrating some of the provider access issues. We have few primary care physicians and behavioral health care providers per 100,000 residents in other parts of the state. We have a greater use of emergency rooms than other parts of the state indicating some access issues. And we have the very low use of hospice compared to national averages. From the provider network side, we have a fairly fragile provider network in the region. More than a quarter of the PPS providers were considered financially fragile. Our institutional based providers do not have a very large data cash on hand. And the COVID, again, is only heightened that that that situation, the pandemic is at additional financial pressures across the North country. So, you know, how do we all bring this together? So we look at the two population health organizations across the region, Adirondack Health Institute and the Adirondacks ACO as being those glue and the fabric to being the community providers together. And if we look at kind of the goals for NCIP, what we're trying to accomplish is a regional wide integrated care model looking at a financially sustainable path forward for all providers. Ideally, a single integrated HIT data platform, uniform quality metrics across providers and payers, integrated and coordinated regional care coordination, assurance of access to care and effective integration of clinical and social supports. And so from a vision standpoint, we kind of look at it as a whole person care the patient in the middle with resources, relationships and connection. That is kind of the triangles around that patient centered or the whole person care aspect. So let me just touch on a few barriers and in needs and then I'll turn it over to Karen for some specific examples related to the ACO. So, you know, barriers in the model. You know, we really would like to see consistent goals and metrics across the region and across payers. We have a very array of quality metrics that really are challenging to keep track of them and keep everybody rolling in the right direction, in the same direction. You know, establishing a stable and predictable revenue stream to ensure provider sustainability. Examples being, you know, global budgets for hospitals, a combination of risk and fee based models for primary care and behavioral health providers to accommodate their readiness towards moving towards a value based payment world. And also payment streams for the non-traditional health care services, the social supports. We'd like to see, you know, continued telehealth expansion. Again, the COVID endemic shined a light on this. We saw an incredible increase in volume of telehealth visits across the region. Over one hundred twenty one thousand telehealth visits in the last quarter, compared to only six thousand the quarter before that, during that, during the height of the pandemic. And we'd like to see the continued expansion of that. And then information technologies, then also known as barrier and something we have to address as we move forward. And we look at it as kind of a three pronged approach that, you know, look at data liquidity. How do we get access to data? How do we turn that data into intelligence? And then the real trick of how do we translate that intelligence into patient engagement and turning it into how do we engage the patients in their health care. Many of the things we mentioned here today have recently been rolled out through the scene in my chartmodels, and this is something we are looking at. We've just announced over the last several weeks there was a webinar yesterday on this, so we are actively looking at this for the North country.

Eric Burton And as we look at needs and kind of ask to keep things going, you know, that's one of our is to is to look at to New York State and the Medicaid program to help engage with us, to explore the pursuit of that chart model in the community track. So we'd like some engagement there to explore that. Other needs, we've already mentioned a little bit around the total cost of care model that would have that predictable revenue stream. Global payments for hospitals, an example. Ensuring reimbursement for care managers, patient navigators and peer supports and payment models also for the social service providers. So trying to be conscious some time here and so that that's kind of the story. And then let me turn it to Karen Lee, who will talk more about some of the specific ACO activities that really show and illustrate how the story is put into live action.

Karen Lee Thanks, Eric. So building on the work that began with the medical home pilot, the ACO was officially established in May of 2013, entering its payer contract under the MSSP program, Medicare Shared Savings Program, a CMS. Since then, the ACO was established agreements with payer under a total cost of care or quality improvement programs, starting with upside only and then moving forward to today, where we have contracts with seven payers for Medicaid, Medicare, commercial. In addition to the MSSP program that are both in level one and level two risk. Of the last two years, the ACO has been successful in these contracts. And today we have over one hundred twenty five lives that are attributed to the ACO, which includes two hundred and forty primary care providers, six hundred forty specialty providers, including behavioral health, over a six county region. Sadly, though, these contracts all have unique characteristics, different data use agreements with varying levels of opportunity and partnership. We do have some alignment on some of the quality metrics with the support of the Department of Health and the Medical Home Governance Group, but there's still a long way to go. These contracts really range from a total cost of care to quality only to sometimes comparing our total cost and quote, our efficiency. So it's a risk adjusted total cost of care compared with peers. But sometimes those peers may be New York City. They may be one of our payers. It's almost all of New York state and understanding that the North country is very different, very different cost, very different opportunities. Sometimes that provide some unique opportunities. The ACO does collect clinical and payer data from Payer 60. We capture that in our population health analytics tool and then we try to give the providers actionable data to help support them with addressing coding opportunities, quality and care gap opportunities and identifying needs and care management. In 2020, with the move to our first level to contract with the Dallas for our manage Medicaid and Harp Lives. The ACO entered into our first participant and risk sharing agreement with the Behavioral Health IPA. The Northwest, which is an affiliation of fourteen mental health and addiction treatment providers across the region. And this is what we see as the next step in addressing whole person centered care. And we are focused in this initial collaborative on improving data sharing and communication between physical and behavioral health providers. And we've also engaged NAOMI, which is the National Alliance of Mental Illness, as our first community based organization to provide peer support and help patients, our shared patients navigate between the two different silos and also to help address any social determinants of health needs that may be exacerbating the health issues. As Eric mentioned, we're also in conjunction with CBPH and AHI leading the HERSA funded project that was recently awarded, a five year project. And it will continue building upon the regional care coordination model that we've built in the North country. We firmly believe that a joint partnership between the AHI, ACO and the region's providers, payers and community based organizations, together with needed payment reform, investments and regulatory flexibility and waivers. We believe we can improve the access to care, stabilize the provider community and improve the health and well-being of

the region and a whole centric care approach. Which include addressing physical behavioral health needs as well as housing, food and transportation. And again, just to summarize, what's really needed to take this to the next level, there's really three key things. It's an aligned model with sufficient payers agreeing to play by the same rules. This includes things such as quality metrics, payment reform models, total cost of care, risk models. Risk models that increase risk over time as we build in capabilities and have success. This takes time, you know, just putting providers into risk arrangements without support and time to build the infrastructure and the collaboration can be really harmful. The other thing we're really looking for in our model is the geographic attribution so that we have enough patients, given that we have such a large geography and a small number of lives across that large geography, we have to have enough people in the model to make it work. If we're really going to redesign the health care system, we need all of the payers to play. And we need more lives and in the model. The second thing we need are investments. This includes things and investments from from multi-payer sources. So we envision this being grant, federal, state, payer, commercial payer, you know, all sorts of contributions as well as the provider community. In this NCIP project, at one point we were adding up the hours we all spent designing this model, and it was just phenomenal. And I don't know at the top of my head how much it is today, but it's significant amount of resources that the regions put into this effort. But we need communication technology. We need investments in primary care, behavioral health, community based organizations and other agencies to provide non-traditional services such as care management, peer support, community health workers, food, housing, transportation. These are all significant issues that affect the well-being in a country in a population such as ours. We need health care system redesign, you know, to ensure that we have the right access at the right place at the right time. We're not like New York City, we don't have multiple hospitals within a short distance where people can travel. So we don't have surgery centers. We don't have outreach lab and radiology. And a lot of our care is provided in the hospital. And with COVID, when you have very little access and all of those services are shut off, there's really a barrier to care. And so building access and the model to allow for additional outpatient services is really needed. And thirdly, the regulatory flexibility and waivers to remove some of the barriers and reduce administrative burdens is important. The telehealth waivers, as an example, was tremendously helpful in getting additional care for people looking at point of service restrictions, you know, where people could potentially get vaccines co-located of providers. One of the things we really would need support on is a single data use agreement across payers. Every payer interprets what data they can share on a shared differently. So having data elements from seven, actually I have eight. Seven commercial plus MSSP. You have eight different payers. Is very problematic in pulling together the data together. So we try to get providers as an example. Quarterly quality gap reports that cross all payers, so they're not having to get a report from each payer. So I'll stop there.

Ann Monroe Eric, is there anything you'd like to wrap up with? We have few minutes, if you do.

Eric Burton No, I think between the two presentations, I think that tells the story, I hope.

Eric Burton And we'll be happy to answer questions after the other interviews. And again, thank you for the opportunity. We really welcome the opportunity to speak to the panel here today and tell the story of what we've been doing in the North country and what we continue to strive for. So thank you for having us.

Ann Monroe Well, let me ask you a quick question before you spoke about the magic of telehealth and how well it works. We heard a lot last week about people that having access to broadband, not having access to devices that they could use. How have you overcome that in such a large rural area or does that continue to be an issue for you?

Eric Burton Yeah, I mean, we do have a couple of grant programs related to our telehealth where we've been able to provide some equipment. And we recently we awarded a grant through the Cherubini Cabrini Foundation to help deploy some equipment to help with that. We know the broadband. One example of creativity across the region is we had a provider that opened up their Wi-Fi access by allowing patients to come into the parking lot to access Wi-Fi. So they may not be able to have Wi-Fi in their residence, but they could drive to the parking lot and have a telehealth visit sitting in their car with the Wi-Fi access. So creative approaches to solving some of that broadband issue in the North country.

Karen Lee Yeah, we definitely do need additional support there, but the creativity that we saw and that we continue to see in the North country is amazing. We also had a provider who was using tablets and could take a tablet to a car if someone didn't have, you know, a device to use. So there were a lot of different interesting and innovative solutions to do work arounds. But there's definitely additional support and work needed.

Eric Burton And we saw that in the education world too, where the community college here in the Falls region, had some students didn't have Wi-Fi access. So again, businesses opening up their parking lots to allow students to sit in cars and access that Wi-Fi to do their online classes, while the schools were in the shutdown mode.

Ann Monroe Okay, well thank you, two. We'll be back with questions, I'm sure. Let's move on now to the other end of the population continuum, moving from where there's one person per square mile to where there's, you know, one square mile to a million people. And that's Maimonides. And David, I said you started with this district, but I believe you probably started with telephones. And so I'm going to turn it over to David and Maurice. And again, if you have questions for any of the panelists, please write them in to chat. Thanks. David, Maurice, take it away.

David Cohen Thanks Ann and thanks for inviting us to participate in this discussion.

David Cohen If you get sort of interesting, if, as you said, and if we really shrink the geography and really expand the population. Basically what they said, everything that you have discussed in the North country really does pertain, even though the distances are short.

David Cohen Times are long. Access is a problem. I'm going to talk about the development of a collaborative model here in Brooklyn that really started with a clinical problem that we were trying to solve. And that was I'm coordinating for services for very vulnerable patients who are being discharged from the hospital in the first instance. Patients with congestive heart failure who were being readmitted with great frequency and then also a group of patients with behavioral health problems were having a difficult time having their general care needs met. I always love presenting this history because it's so revisionist and sound, so purposeful and linear, and in fact, it never is. But we started about fifteen years ago looking at those two problems and realizing that in order to solve them, we needed some way of communicating better between hospitals and partner organizations out in the community in the first instance with congestive heart failure with

our home care agencies. In the case of behavioral health, it was with a huge number of community based organizations providing services for patients with severe mental illness. So in pulling together maybe fifteen partners who represented those different kinds of services, we started to do what we thought was the simple process of putting together a health information exchange. It was way more complicated than we anticipated. But it really did result in the creation of the Brooklyn Health Information Exchange that continues today as part of Health X. We also needed a way to share information among multiple types of providers and actually have someone who could coordinate care for them. That resulted in the development of the Brooklyn Health Home and the development of an entire group of care managers who were able to follow patients and ensure that they were able to go from one site to another relatively seamlessly. We needed a communication platform for those care managers and worked with the vendor partner to develop that. So we had the various elements of being able to manage a complex population. And we needed to prove that we could really use health information exchange to do that. So with support from New York State and grant, we started to look at the management of patients with severe mental illness, making sure their general care needs were met. We subsequently received funding from CMNI and really brought that program to scale and demonstrated over the course of three years that the economic model worked as well as the clinical one. On a base of six thousand Medicaid patients, we were able to reduce costs by forty eight million dollars over a three year period. So the question then was, could we develop value based program that would really take advantage of all of these various components and along came the Disrupt program.

David Cohen So what we have developed served as a terrific model for it.

David Cohen The original fifteen organizations who were working together expanded to thirty and then fifty. We all started to plan for the district program, the governance structure that we had put in place for our original health information exchange really was scalable. And so we expanded it with an executive committee an I.T. Committee, Clinical Committee, Finance Committee that really worked on behalf of an entire set of organizations that could really start to work together in a meaningful way. And so Community Care of Brooklyn was created. One partner brought in another. And we have now a partnership of a thousand organizations across the borough, which seems really unwieldy, but actually works because the governance structure is really an inclusive one. It's transparent and it is consensus driven. And I think that most of our partners have participated at one level or another in that structure and feel invested in it. We expect that over a period of time, interest might wane and in fact it has only increased. Our PPS was and still is responsible for patient attribution of about six hundred fifty thousand or half of the Medicaid population of the borough of Brooklyn. And our community, as you all know, has extraordinary needs, not much different from those described by Eric in the North country. But with high per natal mortality rates, high advanced mortality in people who should not be dying. It's a population that's difficult to reach because of the great diversity. And it can really only be done through partnerships, through organizations that have real inroads into different communities. So when we approached district, instead of looking at the individual projects, which tended to be rather transactional, we tried to figure out what were the real transformational activities that we ought to pursue.

David Cohen And we we put them into two major buckets, one around the transition of care from one level of service to another and the other around advancing primary care, both in terms of number and access, but in terms of also in terms of the services that could be provided.

David Cohen And a third bucket really integrating behavioral health and primary care to really improve the population's health across the borough.

David Cohen So in order to do that, we really had to deal with the development of our workforce. We had already developed programs to develop a career ladder for care managers.

David Cohen It was really important now for us to look at extending that to embed care managers in some way in primary care practices. So we developed a program at Kingsborough Community College to train medical assistance to become health coaches. And that is a degree granting of credit granting program that is currently active. We built our information technology infrastructure, both in terms of analytics and in terms of being able to communicate with all of our partners. And that really has been a key to both identifying partners who need assistance and making sure people have access to services. But frankly, none of this would have really made a difference if we were unable to really reach into the communities in a much more material way and hear from the communities, what they want and how they felt there should be organized. And so a huge effort around engaging opportunities was developed to and ultimately led by Maurice Reid. And I want to turn it over to him to describe some of those activities and then I'll come back just to finish up with where we are and on going.

Maurice Reid Thank you, David, and good morning, everyone. Yes, I guess about eight years ago and maybe longer. The impact of hospital closures began to be felt and seen in Brooklyn, especially in the central Brooklyn communities that led to the formation of a coalition to save interfaith hospitals. That coalition, which was made up of union leaders, churches, business people, community based organizations, helped to stave off the closure of interfaith and precipitated the formation of what is now called The One Brooklyn Health System. Having been raised in Brooklyn and in Bedford Stuyvesant, in Brownsville, many of us decided that we had to continue this process are going forward. So we looked and concurrently with what was happening at two nominees. The district program gave us an opportunity to really take get some resources to really take a look at what has happened in the community. We were convinced that the only way to approach resolving or solving some of the problems in our community was to really get an underground into the community and hear from the people in the communities as to how they saw the issues and how they saw resolving it. I think we're all familiar with the process that was primarily used prior to that, which are professionals coming in and telling the community, this is what you need to do. And we like to call that over and over in terms of the community. We were fortunate enough with the help of the nominees to the district funds to engage the MIT CoLab, which is a community based part of MIT to help us develop a project which is based upon participatory action research. Participatory action research, say, going into a community with community folks and saying, what do you think? What's the problem? And how do we resolve it? That process started in I guess it was 2016, we actually did the first what we call a PARS Participatory Action Research Study. And it was focused on following up on to New York City Department of Health Community Health profiles, which had identified the tremendous disparity in life expectancy between Brownsville and Upper West Side in Manhattan. A ten year difference in life extend expectancy and also many other issues that we now know traditionally that we now link and call the social determinants of health. I hesitate with that term, but it's real. So the studies that we engage in in the first two studies, part one and part two were in Brownsville, East New York and Bedford Stuyvesant. And out of our stories, although in many ways those communities are similar, they're also different in many ways. But the same theme came out of all of them. And that was that we needed better housing. That there were issues of food, food insecurity. And

the concern about violence and its impact on the lack of exercise. Folks are afraid to go to the parks because if you go on at eight o'clock or six o'clock in the morning, you're facing some issues in terms of potential violence. Utilizing the services of local community, the World Academy for Total Community Health high school watched students who live in Brownsville, East New York, , students from there who live in these communities. And with did the first study and again, the recommendations that developed out of the first study, we would think had a tremendous impact on developing what is now called viral Brooklyn Initiative that the government announced in 2016. And that was a critical part of the process that we were able to go back to the community and say to folks, hey, see, we took your word, we put it together, and we reported back to the community and several officers several ways over the last several years. At the same time, in conjunction with Maimonides, we decided to form a community action and advocacy work group, which essentially helped to meld the operation that was going on at the Interfaith and One Brooklyn with the home health homes activities that district that Maimonides's was involved in.

Maurice Reid Again, fueled by the finance in the district. And together we've been able to maintain an ongoing, collegial working relationship with them. I think over one hundred organizations actually participate in a regular activities with the CAW. We were determined not just to do a report and I have it sit on the desk and so part of the follow up was what we now call Eastbrook and call to action, which is a process of going back into the community and saying, okay, couple of years ago when we did the research, this is what you said. Have you seen any change? What do you think about the the housing that's being developed and asking those questions. We'll actually be doing a specific follow up in grounds over summer, related directly only to the housing anywhere were in terms of PARS. So that's the community piece of it. We were able to integrate a lot of folks who, as my brother Bruce would say, operated directly in silos and never really talked to each other in terms of achieving, in many cases, similar goals. But we're operating separately. And I think what we've been able to do is to bring everybody around the table and now through Zoom through to actually continue to communicate, to do certain things going forward. Recently, again, we said, well, what do we do? There are real issues in the community in terms of resources, economic resources that we're lacking. There was no loss on those people who had ideas for resources to actually implement them was was critical. So the one the Brooklyn Community Collaborative was formed. Based on a model that you might have heard, the Cleveland system of anchor institutions in Cleveland, Ohio. And the nature of that is to utilize the the strength of institutions like Maimonides, like One Brooklyn, CUNY and take those resources and help them to provide resources for community based organizations that would not ordinarily have access to funding from foundations, for instance. And so we put that together as an opportunity to become a vehicle for helping the community in a very direct way, addressing the the root, the issues that they saw, but with providing the resources that were necessary to do that. The focus has clearly been on housing, to a great extent. And secondly, on economic development, we, you know, COVID while we've been fighting this before. COVID, essentially really highlighted the fact that in our communities we didn't have the resources to provide PPE or any of the resources that were needed to actually address the issues of fighting that disease in the hospitals. So part of our plan is to extend the economic development activities and we're looking at, for instance, warehouses and within central Brooklyn, utilizing funds that are now directed by our hospitals outside of the community and through the supply chain. Billions of dollars are spent in New York City hospitals. Very little of it comes into the New York City communities, and almost none comes into the communities that we serve in central Brooklyn. And so our focus is to help to redirect some of those resources into our community in a way that is beneficial care management. Of course, all of this comes back

to how do you tie these all social activities to better health. And when we talk about housing, we're just not talking about putting up an apartment. What are what are the services that are available there? Can you attach to a housing complex medical services that are available. If they're seniors in the housing, how do you communicate so that if somebody falls down and inside, they don't have to, you know, they're not alone, they can immediately contact the health center that's right there on their own on the premises. And a lot of that, again, comes from my background in Brownsville at the Brownsville Multiservice Family Health Center. I had the great opportunity of being there and I thought I was retiring when I left about eleven years ago, but Harvey and others have made sure that I don't. And most recently, the, to really focus on economics and the resources. BCC has established what it's called Strong Communities Fund. And what we're essentially doing is providing resources to organizations that have critical cuttack capabilities, but didn't have the resources. They could not go to large foundations and received funding. So there's strong communities fund through BBC becomes a vehicle for receiving some of those funds and then dispersing it into our communities. We started the first round. I think we've already allocated close to a million dollars to the local community organizations. And the critical piece of this, though, is that it's been a long venture and it's not going to end soon, that we've developed a partnership and a relationship of trust between the various participants. And we've translated that back into the community in a way that has become very effective for us.

Ann Monroe Thank you, Maurice, back to you, David, for a wrap up. And then there are a couple of questions.

David Cohen Thank you. So, you know, five years later, we have been successful in achieving what we had set out to do with the district program.

David Cohen We've decreased preventable readmissions by thirty percent over for the last five years of district. We've provided eighty thousand high complexity patients with care management services. We've achieved a ten percent reduction in recidivism among those who have criminal justice system involvement. We've harvested thirty thousand pounds of produce grown by students in central Brooklyn in hydroponic farms that we've developed. We've established a career ladder for two hundred and twenty five medical assistance who were trained at Kingsborough Community College. We've provided over fifteen hundred staff from one hundred fifty six organizations and fifty thousand hours of training. But as Maurice said, the most important thing we've done is develop real durable partnership and a scalable governance structure that will enable us to continue our work. We've developed two successor entities. Brooklyn Communities Collaborative that you've heard about, and CCPIPA, which is a venue for contracting value based contracting. And I would say, most importantly, we've really helped catalyze movement in our communities.

David Cohen And assisted them in their own self agency as they develop programs that lead to community health, wealth and cultural vibrancy, that is our story.

Ann Monroe Well, thank you, David. Someone had a question regarding that health care coaches training that you talked about at Kingsborough Community College. How did you recruit for that? And was tuition assistance provided? In other words, how broadly was that offered in Brooklyn?

David Cohen Yes and yes. I think we recruited from our partner practices. We have several hundred practices across the borough. And it was primarily their medical assistance who were recruited to participate. And their positions were either backfilled or

we provided over time to make sure that they were covered and the time that they were out. It is a community college. They do get credits for it. And some have gone on to train well beyond being health coaches and to nursing.

Ann Monroe And tuition assistance?

David Cohen Yeah.

David Cohen Yes.

Ann Monroe Okay. What's the plan, Jeff Crowd asks, what's the plan for sustainability now that additional district funding doesn't appear to be forthcoming. And he specifically read it to the CCC and you could now remind us what that is.

David Cohen CCC.

David Cohen So CCP is the performing provider system that we developed under the program. It actually is not a separate entity.

David Cohen It is Maimonides and we have individual master services agreements with all of our partners to participate. And those the activities of CCP will continue under that venue until there is some additional other sorts of funding. But CCP has supported a central services organization that has managed the activities of disrupt. It also has a contract to manage the health and the IPA and Brooklyn Communities Collaborative. So there are other sources of funding to support that. Brooklyn Communities Collaborative as a five oh one C three. We have been engaged in seeking other funding to continue support for that which will in turn support our community based providers. The IPA is a going concern. We have value based contracts with several Medicaid managed care providers and we also are in ACO participating in the MSSP program.

Ann Monroe Thank you, David. I thought, well, what's most important, there was Maimonides commitment to continuing this work, even if, even if the funding from external funding is not provided, you have a commitment from this system to continue to fund this work.

David Cohen We also have a great hope that perhaps in a new administration we'll see another waiver.

Ann Monroe Well, let's see what happens there. There was one last question.

Ann Monroe Maurice, when you were speaking, you seemed to hesitate over the term social determinants in health. Was that just because it's hard to get off your tongue or do you have some feelings about those social determinants and how that should be either implemented or addressed?

Maurice Reid Well, yeah, it's actually both. I think, you know, I hesitate on that. But what I'm afraid of is that we use these terms. We don't really fully understand its implications in our community and reverts back to, well, it's those folks who don't have the capacity to do what they're supposed to do. And that's that's my concern, that we don't really use it as a label without understanding its implications in the community.

Ann Monroe Thank you. That's for another discussion someday.

Ann Monroe But I'd like to turn it over to the third integrated program that is between Emblem Health and Advantage Care Physicians and Karen Ignagni and Navarra Rodriguez will walk us through the partnership and how it's fairing in the new world.

Karen Ignagni Thank you Ann, and good morning, everyone. It's a pleasure to participate. I thought the first two presentations by the four speakers were just terrific. So it was an honor to listen to that. Navarra and I are going to do five things. First, I'm going to introduce our enterprise of Emblem Health, Dr. Rodriguez is going to introduce ACPNY. We're both going to comment on how the plan and our physician group work together, but also independently to address some of the challenges that no one expected with COVID. We want to both discuss disparities and some observations we have as a result of COVID, but also as a result of really focusing on primary care. And finally, we're going to finish with some recommendations. So that's the arc of what we're going to do. I'm going to introduce, I'm the CEO of Emblem Health. And we're unique for four reasons. We're first, a not for profit health plan. There aren't many left. We're very proud of that. We were started about 80 years ago by Maryla Guardia, who had a vision that he wanted an opportunity for city workers, public health workers to have access to affordable, high quality healthcare. So that's the first point and our plan was born. But at the same time, predecessors of ours thought it was very important to succeed in this mission. We needed to have a strong alliance and partnership with a physician group, both a primary and specialty physician group. And that was the planting of the seeds for what is now ACPNY, which has come a very long way as our health plans come a very long way in those decades. The third pillar of our health plan is very unique. We have twelve neighborhood care centers that are located throughout the various borough, but are focused on helping with social services, putting people in touch with resources to deal with food issues, rent, apartments and a range of other disparities that people deal with every day. In addition, we do diabetes care, treatment and coaching. We have just launched a pregnancy journey, a very new thirty six month effort and program for individuals, new moms. And we deal not only with our own members of Emblem Health, which we have three point two million, but we also make those services available free of charge for the community. So prior to COVID, you'd see Zumba classes, meditation classes. Our most popular class, ironically, and I hope I won't make people blush in saying this, but people found our classes on sex over 60, very, very popular in our neighborhood care centers. We wouldn't have expected that, but men and women found them very important. So there you go. Our fourth pillar is that we were the first health plan to partner with an organization, a Google backed entity called City Block, a new organization.

Karen Ignagni They are functioning as our health home and they are working with Dr. Rodriguez at ACPNY. They're located within a ACPNY in both East New York as well as Crown Heights right now. And we'll be expanding that to actually help deploy not only physicians, social workers and nurses, but health care workers to meet people where they are at home and deal with all of the intractable issues that we know people have. So with that, let me hand it off to Dr. Rodriguez, who's going to introduce ACPNY.

Navarra Rodriguez Thanks, Karen, and thank you all for letting me join and share our story. I'm proud to represent Advantage Care Physicians, ACPNY, as we call it for short, which is one of the largest primary and specialty care practices in the New York metro area. And our practice is caring for half a million patients across 41 offices in all five boroughs of New York City and out onto Long Island. And I'm proud to say most of our staff are providers.

Navarra Rodriguez Our nurses come from, live in and work in the communities that we serve. So we understand as a practice across all aspects of the practice, the unique opportunities, the challenges that each boroughs, each neighborhood has. And that has really formed our approach to developing a care model that meets the needs of patients. That care model is one based in patient centered medical home basics, but one that is patient centric and focused on the needs of an individual. Echoing what I heard my colleagues say before, that whole person care. And as you would expect, there is a strong emphasis on primary care, promoting wellness, prevention, managing chronic diseases. But on top of that, we offer many other specialty services to help bolster primary care services, including gastroenterology, cardiology, women's health, haematology, oncology, ophthalmology, podiatry and behavioral health. Things that we think are necessary to enhance care coordination and make sure that we're offering comprehensive care to the neighborhoods and the communities that we're in. In thinking about our collaboration with Emblem Health, where I think we've been very successful over the past several years, is in three main domains. The first in terms of closure of gaps in care and that is really been served by our ability to have comprehensive, timely data information sharing from the plan and the practice so that we're able to identify when patients are missing needed care, if there are things that we can do to help bolster our outreach efforts and our care coordination efforts. The second area that we've been successful and Karen commented on it, has been with our ability together to address more social determinants of health. And like Maurice, there are some terms that are sexy terms, but we'll use them today. We know that patients need services and with the support of neighborhood care, Emblem Health Care managers, City Block, ACPNY has been able to expand what we view as our care teams. What we think of as our care teams and people who can serve our communities and address and make sure that patients who are facing food insecurity, who have questions about insurance coverage, who have concerns about cost of their medications, can quickly be connected to resources that help support them and get them the care and services that they need. Last but not least, I think one of our great efforts and great successes has been in our ability together to enhance patient engagement and enhance and improve patient education. And as we were facing COVID and anticipating and learning more about COVID, this was quite apparent how collaborating together plan and practice would better prepare our practice our communities and our delivery of services. And Karen, I don't know if you want to comment a little bit more about that COVID response.

Karen Ignagni Yeah. Thank you, Navarra. We had to step back as a health plan and rethink almost everything. And that sounds like a toss off, it's not. We really had to think about how our members would get services in a pandemic A, that they needed. How we'd get them information in real time and our responsibility to play the role of an honest broker of information.

Karen Ignagni And people were particularly in March and April and early May, very, very concerned. They, you know, this was all new. So we stopped and stepped back and said, how can we put up a micro site so we could get feeds from CDC, from the state, from the city and make information available in real time. We did that very, very quickly at the end of February because people were flooding our call centers. Navarra and our chief medical officer at the health plan, Dr. Del Cole, would do weekly calls with every customer service individual we had to make sure we could answer their questions because they were on the front lines. We worked very, very quickly with the state, with the city to harvest information. And we knew that ACP was going to be an important partner for the city and state for testing and a variety of things. But at the same time, that information was very important. We also realized that people were afraid to go out. So we needed to think about how we

retrofitted access to pharmaceuticals for people with chronic illnesses. Where could we get people ninety day prescriptions? Where could we do real time information delivery? And we actually found a new company developing, which now has gotten a lot larger. But we did a contract with them called Medley and they did home delivery for us. And then we talked with Walgreens and CVS, we had a great partnership with those entities as well to make sure that for people who wanted delivery, they could get it. We also made forty five thousand outward bound calls to people we knew were high risk of, they had chronic illnesses and they were high risk, but also to people who were rising risk that we knew that if they didn't have certain treatments, if they didn't have certain interventions, pharmaceuticals, they would be in that high risk category. And what was really striking is how valuable that outreach was and we marshaled everybody to do this. Physicians, nurses, social workers, customer service individuals. We trained everyone. And we actually just reminded people to first ask, well, how are you doing and listen. And then we harvested that information, g. Got people what they needed, got transportation when they needed transportation, etc. And we spent a lot of time helping people understand the very miasma of testing and all of the information that was very it was both conflicting in the early days, but it was confusing also for people. And then we dealt with loneliness by calling individuals who indicated that they were alone and calling them back and harvesting our neighborhood care teams to do that and helping people just get directed to unemployment compensation resources. Small businesses directed to federal resources to help them. And we never expected to be, you know, in that arena. But, you know, just necessity is the mother of invention. And so we really turned our health plan. We opened the windows and turned our health plan outward. And Navarra, do you want to pick up from standpoint because you are such an important partner for the state and the city in testing and treatment, et cetera?

Navarra Rodriguez Absolutely. You know, in face of the pandemic, ACPNY quickly implemented and deployed strategies for us to screen and test for COVID-19.

Navarra Rodriguez And that transformation was also supported by education, like Karen mentioned from call centers, Emblem Health, getting the word out about how to access care and how to look to ACPNY as a resource. We were able to rapidly implement virtual visits and telephonic check in visits. And this was huge for us in which we were able to cover and provide access for most primary care types of visits, as well as many specialty consults meeting that our patient care needs of both COVID and non COVID conditions. And, you know, early on in those days in March and April, I think everyone forgot about diabetes and hypertension.

Navarra Rodriguez You know, it really focused like lasers on COVID. But we didn't forget that there were a whole bunch of patient needs that were non COVID that needed to be met in the outpatient setting.

Navarra Rodriguez So, for example, patients who might have been experiencing anxiety because of the pandemic at that time were able to connect and get tella therapy with our behavioral health specialists and that continues through today. Or patients who are diabetic, who needed to work on glycemic control, could continue to work with their endocrinologist, their nutritionists and their primary care teams to ensure that remotely they still stayed on plan and could meet their health care goals. So leveraging technology for us all really transformed our practice in which we were able to make care more convenient, easier and safer for many patients to receive. And it also has allowed us, as we've gotten past the surge, to really think about how we can maintain social distancing in our offices when we know there still are patients who need in office care for things like

chemotherapy infusions, colonoscopies, endoscopies, cardiology, stress testing, biopsies and the like. And so, you know, I'm proud to say we were able to quickly implement these new workflows to quickly think about how we could maintain access for needy patient population and educate patients, especially during those difficult times. But at the same time, I hate to say, when we all know COVID-19, has highlighted some significant societal inequalities that cause worse health outcomes for patients and communities, especially Black, Latin X and low income communities. And so thinking about this and how these communities are already hard hit and suffering from higher rates of chronic disease and lack of access to primary care services and specialty care services really has spurred us as an organization in a practice to say what can we do? That's why, as Karen mentioned, we've partnered with city and state officials to quickly ramp up COVID testing, COVID testing in hotspots that we see popping up across New York City. We've quickly leveraged it and opened up twenty testing centers as we were hitting the peak of the surge. But our outreach strategies as well have been refined and are aimed at closing gaps in patients who are vulnerable. Those who are in historically underserved communities and those who are fragile. And we know that if we intervene early, we will be able to help them stay on a path or better health outcomes. So, you know, as I think about our past in the past few months and consider the terrible possibility of the second surge of COVID coinciding with flu season this Fall, I think it's very important for all of us this year, more than ever, to think about how we can be proactive from the practice side, from the plan side, from the public health perspective, and be proactive in protecting New Yorkers. I also think it's critical and this may have come out in some of the conversations with primary care leaders last week that it's critical for us to recognize and support community based care. Community based primary and specialty care as an essential part of solution and reducing health care disparities and that we need to support economically and fund that to do better and serve serve the state and the citizens well.

Navarra Rodriguez And I know Karen has a lot of ideas because we've had many conversations about how do we do that functionally, efficiently and effectively.

Karen Ignagni I want to come right behind Navarra and say that one of the benefits at ACP as a patient, I can go to any one of the forty-two medical centers and My Epic record follows me. We can go to any hospital that most hospitals use Epic, and that's a great thing, but as we were deploying all of the virtual health that Navarra talked about, we realized that there and Maurice talked about this. There were some real issues in various communities with respect to access to technology. And Ann, you opened up that earlier on in the conversation. And we see that we actually did a survey of a thousand New Yorkers representative. And we confirmed our hypothesis that in certain communities, there's a real difference in access to technology. There's one device and the person who is working is using the device. The person who hopes to interact with the medical system is using the device or has to use the device. And children have to use that same device for classroom education. And so we are in our neighborhood care centers now making technology more available to individuals so that they can come and have a virtual visit. Doesn't have to be with ACPNY, but they can know it's secure and safe. That's one thing we can do. We can help people charge and give them opportunities for that. And we're going to begin classes. We did a little of this prior to COVID, but literacy around technology, how to use it, how to maximize it, cetera. So we're really focused on what we can do together, our two organizations in partnership to help this digital divide. But it's real and it should be looked at as an access issue to health care. We have five recommendations and Navarra, you touched on several of them. I want to sharpen them up on behalf, both of us. I think what we see is that we all need to be advocates for rebuilding public health infrastructure, both starting at the federal level and CDC all the way down to the local level, but in-between

state and city. And that funding has degenerated over the last twenty, thirty years very significantly. And now we need to all step back and become advocates for restoration and for a public health plan. How do we want to rebuild? And I think everyone who is participating in this wonderful discussion today has an important role and view about that, in that. We think the government needs to play a much larger role. And I'm proud to say that New York, both the state city, is rising to that occasion. But government broadly at the federal level as well, needs to take the responsibility of both testing and the vaccine. We need to approach these issues the way we approach polio and public health crises in years past. And it was much more organized than it is today. And it needs to be organized starting at the federal level and there needs to be resources for it. Three, the government needs to ensure, since government now at the federal level is investing in pharmaceuticals and the work that's being done to develop a vaccine needs to claim its place at the table and ensure that vaccines will be affordable. And government needs to embrace that in our view and needs to be responsible for those costs. And in doing that, they would have a very important role in terms of negotiating these costs. Fourth, we think that looking from an ACPNY perspective, we had to beg, borrow.

Karen Ignagni And I don't want to say steal, we didn't resort to that.

Navarra Rodriguez We didn't steal.

Karen Ignagni PPE because the obviously hospitals were the first area of focus by the federal government, by the state. But if you're running primary care practices and we kept our practices open throughout the COVID problems in the pandemic, and we will again, if we have a second wave. We didn't have access to any PPE. We had to find it ourselves. We think that government has an important role in the supply of PPE and the distribution down to the local practices in addition to hospitals. Finally, we need a primary care strategy. This group has talked about that. There needs to be both a national statewide city, local primary care strategy. And how does it relate to the public health strategy? And how do we rebuild and how do we develop a plan for first, second and third? We'd like to participate in that, but we think that it's going. It needs to be multifaceted and all of us have an important stake in it. So, Ann, those are our observations. We're just tickled to participate and really looking forward to the discussion.

Ann Monroe Yes. And I expect there will be greatly. If each of you or maybe I'll just start with you, Karen and Navarra, since you have the floor. What are some specific regulatory and financing actions that you think would be most important and what role does the state play in that? Are there specific regulatory changes that you think need to be made to sustain and spread the model that you're working on and then I'll go to our other two presenters for those same questions.

Karen Ignagni Well, we just went through a number of very specific recommendations. And I think that it's very important to have a conversation about the role of government in testing, in vaccine development, in vaccine setting, prices for vaccines and a range of other issues that we haven't had to really tee up as a society for decades. So I think polio does, my Mom had polio. So it's something that is very close to my heart and my family. That offers, I think, some real lessons as a first matter. And then I think, as Navarra observed, you know, this this issue of technology disparities really has to be put there front and center as we think about access to health care. If so much is now going virtual and I don't believe we're going to go back. We have to think about and if we were having an educational forum, we would say the same thing. We need to think about how to put devices, affordable devices that work that are effective in people's hands. And as a

society, we really haven't begun to unpack that and think about how that would be done. I think, yes, the state has an important role. The city has an important role, particularly such an important city in New York. But I do think the federal government really needs to step up to the plate and commit significant funding. When there was some funding that was committed and the Cares Act now Congress has another chance. The first thing Congress should do, in our view, is fund the states and the cities that have been so hard hit, which would include some of the priorities we're all talking about. But that would be it would be malpractice for Congress not to tee up resources for states and cities that have been suffering as a result of this pandemic. We see it from the health plan. Navarra sees it from the ACPNY with our patients and we all have, again, a stake in advocating for that.

Ann Monroe Great. You might think about it. We'd be open to any written additions that we'd like to have about. You know, we are the Public Health Planning and Public Health Council for the state, the Department of Health. So if you have any specific thoughts about rules and recommendations related to that, to the Department of Health, it would be useful for you to send those to us as well. And in that spirit, let me turn to David and Maurice.

Ann Monroe Any specific recommendations around regulatory issues that would help spread what it is that that you're about?

David Cohen Just a few. In the disrupt program, we have the luxury of being able to plan together without fear of antitrust regulations. And I think that our ability to continue to plan together for the public good really needs to be dealt with in a meaningful way. Our ability to have data and share data among our partners is has been key. As I said before, in identifying where there are gaps in services or where individual practice is needed assistance and our ability to continue to receive those data and share them would be absolutely key.

David Cohen It'd be really nice if we could pick a path in terms of what we're going to support.

David Cohen I think that by creating a lot of the collaboratives among various interest groups with simply perpetuated silos, I think if we can identify those organizations that are working well as real collaboration's that they ought to have more ability to work with the full range of organizations.

David Cohen I'd rather not see a separate behavioral health collaborative and a separate CBO collaborative and a separate general air collaborative. We all have to come together on this.

David Cohen DBP is a really nice thought in terms of a funding stream to support more than medical care, but I think that the medical care dollar is pretty stretched as it is. And as we start to make inroads in terms of caring for other social issues. If we can demonstrate a decrease in recidivism within the correctional justice system. There's got to be a way to start looking at attaching those funding streams to support sort of the collective effort.

David Cohen So those are a few ideas.

Ann Monroe Thank you.

Maurice Reid I would like to just add in terms of the coordination. We currently funded separately health care housing and all the other things that are impact on an individual.

Maurice Reid But when we need to see ways in which we could fund collectively because what it impacts one individual and a family not only could impact the rest of the family and but they're forced to actually operate in silos rather than operating cooperatively.

Ann Monroe Thank you very much, Eric and Karen, anything from you that you'd like to see happen at the state level to make your effort more smooth and more sustainable?

Ann Monroe Eric, you're on mute.

Eric Burton Can you hear me now?

Ann Monroe Yes, we can.

Eric Burton Can you? Oh, sorry, technology difficulties. I think we mentioned in our presentation and is repeating, but a single data use agreement would be very helpful.

Eric Burton Of all the different rules by payer as how it did is shared is challenging. The anti-trust issue that David mentioned, t. That's also a challenge for us as we continue our planning efforts with the NCIP, so some some help on that aspect would be helpful.

Eric Burton You know, we also mentioned in our presentation, you know, some changes in being able to to have predictable revenue streams. So, you know, reimbursement models that that are different know assistance to advance to that quickly and possibly some investment in upfront protection for providers that are in a financially fragile situation to be willing to jump into those type of arrangements. That's been a challenge for us with a fairly tight balance sheet. Have partners be willing to enter into those. Karen, I'll turn over to you then to add some additional thoughts to that.

Karen Lee Yeah, I definitely want to focus on the reallocating of funds and the state's role in that.

Karen Lee I really do believe there is enough money in the system, but it's everybody coming together that is so key. And one of the things I've really enjoyed about the North country is that ship and engagement. But if you bring the correctional system, the educational system, health care system, the social community based organizations bring everybody together and reallocate the funding invest upfront and some of the things we know will have strong payoffs. You'll save money if you address behavioral health that will save the hospitals money. It'll save the correctional system money, but there are some investments that are needed up front. And so part of the value-based payment contracts. It's really trying to get payers and that would include the state to help support some of the investments we need upfront to look at whole person care and to look at how we can address society's needs and the needs in the communities so that we don't have these exacerbating health issues. I think that's just so key. Payment reform, like Eric mentioned and I mentioned, is so important. You know, when we had COVID and our hospitals were shut down and we didn't have the big surge that others did, you know, that they were struggling before COVID and this is just made the problem worse. Having a global budget, being able to reallocate resources to reach out into the community is so important. I know there's a lot of other things that that we touched on, but I'm happy to follow up with some other thoughts too.

Eric Burton And I think, as I mentioned, too, of being able to provide additional information. We have been working on a regulatory waiver type document I don't have in front of me, unfortunately. So, yeah, we would welcome the opportunity to be able to share that with some thoughts of regulatory reforms and so forth. So if we could follow up, we would like to do that.

Ann Monroe We would love to see that.

Karen Lee I just want to mention one thing. So one of the things in the Medicaid Value-Based Payment Roadmap we've seen, as I mentioned before, we have seven different contracts with payers in addition to the MSSP program and the different models.

Karen Lee And, you know, very few of them actually follow the Value-Based Payment Roadmap. And I know in the Medicaid, there's funding that was to be made available to be pushed down to the provider groups and to the risk taking entities that we're not seeing in full. And so support in that area would be useful as well.

Ann Monroe Great.

Eric Burton Well, one more thing, if I could circle back. I know we mentioned it in our presentation, but that broadband issue, I want to bring that forward again.

Eric Burton I don't think that can only be a community based situation to have to deal with to be some governmental level resources available to improve the broadband access in the North country. So we want to mention that again, I know we talked about it multiple times in our presentation, but that is the key point.

Ann Monroe I think it's a key point in the urban areas, too. We heard caring about the availability of multiple devices becomes an issue, which if you don't have broadband or Wi-Fi, does it really matter what you have.

Ann Monroe Dr. Lawrence says a couple of questions and we'll start with Emblem. What are some of the ways that we understand your close and very effective relationship with savage care physicians? How do you collaborate with other communities, safety net primary care providers? Are they as critical in your network as advantage care physicians? How would you talk about your relationship with them?

Karen Ignagni Yes, most definitely.

Karen Ignagni We actually have a very I think one of only two relationships with Somos, which is a level three participant in the state efforts. So we're there their partner. Our partnership has been approved by the state. We're very excited about that. That's in Washington Heights, in the Bronx, largely. We have a level I think their level three is pending across the area.

Ann Monroe Tell us what that means.

Karen Ignagni Yes, it is the Asian IPA and they have done an extraordinary job reaching out and making sure that individuals who speak Mandarin, Cantonese have access to high quality, culturally appropriate services.

Karen Ignagni We actually put up a call center in Flushing that is responsible for dealing with and staffing and supporting people who are Mandarin and Cantonese speakers. We have relationships with every hospital in the area. I'm proud to say we are very, very open to doing risk relationships with other groups in addition to the ones that I mentioned. Sometimes there is a reluctance on the part of hospitals in particular, and some physician groups. They don't have the infrastructure to manage risk, so that's frequently the barrier. But we have one of a variety of almost everything in our eco system. So we have the infrastructure to take risks, do capitation. It used to be a term of art in the 80's and early 90's. Then it kind of fell on hard times, now it's back. We have a capitation relationship in Medicaid with, for a very important part, partner for us in the Bronx and now in the Northern part of the state.

Ann Monroe I did hear you mention FQHC's or mostly you're speaking about providers of medical groups. What about the structure of FQHC?

Karen Ignagni We have relationships with three million plus members. We have relationships with almost everyone. One of the things we would love to do with FQHC is engage in risk relationships. Their funding is such that it's a little more difficult for them to do that and we're actually working with some FQHC now to figure out how can we use our infrastructure to help them move on down that path. But, you know, we have relationships with almost everyone because of our market share and the fact and that we participate in every arena, small group, individual Medicare, Medicaid, large group. So the alphabet soup of you name that we have it basically.

Ann Monroe One of the things that we have heard from all of you is about the need to have more either consistency or single data use agreement or across the payers. And I don't expect you, Karen Ignagni, to speak for all payers. But this has to be a kind of topic among payers as to the impact as Karen Lee said eight different structures for showing your effectiveness, eight different single data use agreements. Is there a role in any way for the state to help foster some kind of continuity or consistency that reduces the burden on primary care?

Karen Ignagni Yes, I'm going to give you an answer that doesn't follow type, because I will answer your question, not for all payers, obviously, but for one. We believe very strongly that the state has an interest in key building blocks.

Karen Ignagni Karen talked about one, and I'll come to that in one moment. But before we get to that, if you're a primary care physician, you are getting credentialing requests every month from every health plan. It would make me if I were a primary care physician and had to staff an operation, it would make me crazy. I'm sure it makes every primary care physician crazy because they're not staffed for that. I believe that the state should put together a template and put together an operation that would take over credentialing. And we could have uniformity in credentialing for physicians, hospitals and everybody in between, number one. Number two, yes, we should have data use agreements. And there are things that we in the health plan community can very comfortably compete on, but it shouldn't be access to clear information, as Karen said. We support that. And I think it's important and I'm hoping, as you know, we post November and, you know, we think about public health and we think about a range of things from a perspective, administrative simplicity, I think there's a real agenda there that could be followed and could be supported by reasonable folks. Because there's plenty of room for competition, but there should be some table stakes that people don't have to and shouldn't compete on. And then

we can compete above that. And I think there's a real opportunity now to think back about all of these building blocks.

Ann Monroe Thank you for that. Someone is asking with the enormous deficits at the state and local levels. What are each of you expecting in terms of financial support for the health care and public health systems? How are you looking at that? And do you see this funding deficit situation that we're in likely to impact your collaboration's in the near term? And let me ask Eric and Karen to speak to that. We'll go then to David and Maurice and then back again to Karen and Navarra. How do you how are you planning for this deficit that we're all seeing on the horizon?

Ann Monroe Eric and Karen.

Eric Burton Am I back unmuted, I hope?

Ann Monroe Yep.

Eric Burton So, yeah. I mean, obviously, obviously, everybody's facing the same challenges .

Eric Burton You know, we're looking at how we continue many of the efforts and, you know, we have some resources available still, but we're understanding know that we're going to have to try to stretch that even been farther than we had anticipated given some of the budget pressures. So, you know, that's kind of one of our first lines of defense like this. I would call it a way of trying to stretch those district dollars out into the future more than we had anticipated, where we had hoped there would be additional federal and state support. So there is one thing we're looking at, but also realizing would that it's a limited runway, it will end at some point and would unfortunately put us in a situation where many of the activities we would have a challenge to keep them going without some additional funding source. So let me pass it to Karen to add additional comments to that as well.

Karen Lee So one of the things we're talking about in the region and part of what we've been doing for the last two years is bringing all of the resources and all the people together to figure out how can we better collaborate? How can we become more efficient? And Eric and I've been working and have been working for the last, I'd say probably three months on some integration efforts with our two organizations as an example, not having two data systems, one for AHL one for the ACO, right? How can we combine and be more efficient with data? So we understand, you know, it's it's difficult with dollars right now. And then, you know, we're looking to resources from payers. We're looking for grant opportunities. You know, any way we can find the funding and making sure we're using it very efficiently. I think really could be the value of the value-bpased payment contract is if you can save money. You know, we asked for some investments upfront, but then, you know, the savings goes back to the payers, to the people who pay the premiums to the lives in our community. So that's something we're very interested in as well.

Ann Monroe Great. Great. David and Maurice, what how are you planning for the dark days ahead?

David Cohen In similar ways to what Eric described, we are also looking at what funding we continue to have through the district program. We've already used it to support our partners and in situations where they have experienced significant shortfalls over the past few months. We've also been providing some technical support to all of our partners in

terms of receiving federal funding that may be available, but all of this is fairly temporary. We're kind of in a very sketchy world right now. And it's it's sort of interesting we spent the last five years figuring out how to keep unnecessary visits from the emergency department. And right now, emergency departments are struggling to get more patients. To the extent that the patient is not coming, are able to be cared for in settings other than the emergency department or at home. We ought to be taking advantage of this opportunity to ensure that that's what occurs. And there may be an opportunity to look at the system as a whole. You know, we we we don't necessarily need to reach the same steady state where we started.

Ann Monroe Maurice, any thoughts from you on that?

Maurice Reid I thought David covered covered it very well. We need to reimagine how we allocate funds and to look at things systematically or systemically rather than individually.

Ann Monroe Okay. Karen?

Karen Ignagni I'll jump in, you know, echoing everyone's comments.

Karen Ignagni I think we're all learning how to tighten the belt and do more with less. I think from the practice perspective, that has always been a mainstay. How can we be more efficient in data sharing? How can we be more efficient in care delivery? I would at ask, I think what we have been trying to do as a practice is identify those sites of service that are less expensive. So I'm very glad that E.R. utilization is not as high as it should be because much of those services can be heard in an outpatient setting. And so as we holistically think about shifting care to those less costly environments and think about leveraging technology to make care more efficient and more effective and convenience. I think practices like ours will be able to to really address and think about how we can allocate our resources to the things that are most important.

Ann Monroe Anything else to add, Karen?

Karen Lee Yeah, I really I really worry about the consequences of your question, because the gulf between populations and disparities gets larger with diminished funds. We work through ACPNY and through the health plan very closely with the Health and Hospitals Corporation I know Patsy's on. And they are doing a great job with contact tracing, but, you know, that we need more money for that. And we're going to need more money if there's a second outbreak. I worry about resources declining and the inability to have resources to do even the basic things. We're thinking about where we're needed. How do we think about our neighborhood care operations? How can we make services more available? But you have diminishing resources all across the system. And I worry about access to vaccines. I worry about access to care. As Navvar said, we see more disparities, more gaps in care. And that's only going to continue, which is why, Ann, for me, it and maybe because it's all of my years that I spent in Washington, I think Washington shouldn't be left off the hook. And we are very lucky to have a governor and mayor that's advocating for funding that is urgent and really appropriate for people, states and cities that have been hard hit. And we were lucky to have Senator Schumer as a minority leader, but they Washington needs to keep this call or what we're going to see on the ground is really disturbing and should be concerning to everybody.

Ann Monroe I think to just to add my own thoughts, that in a scarcity mentality, which is what we think we're going into with with no one to having the resources. The temptation is

to hunker down and protect what you have. And that can be a challenge to a collaboration and a collaborative that really wants to keep people at the table. And how do you continue to show that that's a better strategy for everyone than to back up, hunker down and protect what you have and fight with the others for your small piece of the pie? And I'll be, we'll all be interested to see how your collaboration's work over the next couple of years as we move from a kind of resource rich, richer or a bit of basis to one of truth, scarcity and how you hold people together. There was another comment that I just it's not really a question, but it's a comment about the Department of Corrections and the Department of Health and how health issues in the Department of Corrections are looked at in a collaborative way, both with COVID, with the significantly aging population in prisons, and why we need to have twenty-four hour corrections, oversight of people who are demented and don't even ask seriously, not a threat to society. So how we do that and I know up in the North country you have quite a bit of corrections facilities up there. Do you have a relationship with them in terms of looking at health and health care across that spectrum as well? Eric or Karen?

Eric Burton Yeah, we did do some initiatives under the desert program trying to people were reinserted into into the public life and, you know, had some nice training events with the corrections officers and the police force. It's another example of no concern about how we sustain those activities in diminished funding source. So these were things that we funded through digital innovation type awards. And and we do have some concerns about the longevity to be able to continue that activity.

Ann Monroe All right.

Ann Monroe Do any of our panelists want to comment on the other the other presentations? And again, I want to invite the members of the council to add any questions to their learning today. But David, Maurice, the Karens and Navarra, anything you want to comment before we consider this session a success and go about our day.

I just want to say thank you for the opportunity to hear the other experiences around collaboration and the disparate thoughts of what challenges are.

Honestly, what I heard a lot today is that the challenges are the same; upstate, downstate hospital district related.

And I am just inspired to know that there are people who are driving towards making change, impacting health and addressing disparities.

So thanks, everyone.

Ann Monroe Anyone else?

Just to echo Navarros thoughts? I mean, I think there is a real convergence, validity in terms of the issues that were identified and discussed.

And I'm hoping we are all going to be moving in a very similar direction.

And Ann, however, we can help the council, we'd be delighted to do that.

Ann Monroe Well, maybe we need a collaborative of collaboratives to help. Eric, we're going to add something?

Eric Burton Yeah, echoing similar comments. Thank you for having us and it was really interesting to hear the other perspectives and other initiatives and we share so much, even though we're separated by a lot of geography, very similar issues going on. So very interesting. And also, echo, we'd love to stay connected so we can continue to look at ways to advance the initiatives.

Eric Burton And I share your concerns that you mentioned a moment ago Ann, of, you know, how do we continue these collaborative efforts?

Eric Burton It's easier to do in a richer resource environment, as you described it, as the resources become tighter. That's going to be a challenge for all of us to keep people around the table. So, you know, we'll be working hard at that, but it clearly will be a challenge.

Ann Monroe I apologize to Harvey Lauritz, I missed one of his questions and it was for Maurice. Could you elaborate on the impact of participatory action research in helping to identify and recruit the next generation of community health advocates and leaders? How was that experience for you in gauging young people in being of service to their community? What were your jems from that Maurice?

Maurice Reid It's been fantastic. The growth in our young people, I mean, as I've said to people before, the students that were participating in our first what first PARS project. Especially ones from from watch, came back to us and talked about how they changed their career goals. Some were had no intentions of going to college, changed their mind. They're going to college. And they're looking at this as a profession, not only in terms of medicine, but also in the process of research and working within the community. They felt emboldened by the ability to talk to their community residents and to have them react to them in a positive way. We now have, I think, over two hundred students that are collaborating in what we call the PARS alumni. And they work together to help support each other in summer work and in terms of future activities. So beyond the the projects that we've identified, the individual results have been fantastic and we're very proud of that.

And if I could just add to that, you know, as we have been working with the city and planning strategy and implementation for testing across the borough, we decided the best way to do it is to go community by community and find out what they would like. Clearly, if you build it, they will come has not worked. And so we have this group of alumni, students, 150 to 200 of them, who will be deployed to go back into the community to find out what the best strategy for engaging folks protesting would be. So it is not just a group that is off looking at their own individual futures, but continue to be engaged in the future of both our bourough.

Ann Monroe All right. Well, anything else?

Ann Monroe Well, I want to thank our panelists today, all six of you, as well as those who participated last week. T Of the committee's, see this as kind of phase one of our own participatory action research.

Ann Monroe What's on the mind of of people that we believe should be a need to be engaged in this process? The council has several specific roles, and one of which is to really understand it, both health planning and public health, what the needs are, what the

direction could be, and work together among the council and folks like you to bring these things to the fore. It's our intent between Joe and John and me. And Anderson is going to join us and anyone else who wants to begin to look at is there a phase two of these kinds of discussions, where we can bring light to folks who can help the council identify its priorities and make suggestions for things that we might look at. This has been very enlightening to me and I what I'm hearing from my other council colleagues, very enlightening as well. We expect to have kind of a I don't want to call it a white paper because I have certain expectations, but we will expect to put together a summary of what we've heard through these four panels and also are open to looking at other groups that we might bring forward. Some folks who also have been identified as having a particular view of health care that we need to better understand. And so in that spirit, you will be hearing more from us as two committees of the month of the Fitbit. And so, again, I want to thank the panelists, but I also want to thank the members of the council who have taken quite a bit of time in the last two weeks to spend with all of you and all of us and better understand how we might be helpful not only to the Department of Health, but to the communities that they serve and the people that we represent.

Ann Monroe And so with that, I will. Let me just check the chat to see if there's anything more than accolades for everyone in here.

Ann Monroe Let me see.

Ann Monroe Great discussion.

Ann Monroe Thank you all.

Ann Monroe Nicely done.

Ann Monroe Hey, it's worth having those things, right? In this time. And with that, I think we'll adjourn the session. And again, thank you all. We'll be interested to hear how these collaboratives are effective going forward and what lessons we can learn that can be applied in other settings. So with that, I want to thank everyone. And Colleen, do I need to turn it over to you or is everyone free to just exit and go on with their day?

Colleen I think we are good to go. Thank you, everybody, for participating.

Ann Monroe Great.