

NEW YORK STATE DEPARTMENT OF HEALTH
JOINT MEETING OF THE HEALTH PLANNING COMMITTEE
AND
PUBLIC HEALTH COMMITTEE

VIRTUAL PUBLIC MEETING

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MEETING TRANSCRIPT

Jo Boufford Okay, we'll start just because some are on the phone. My name is Jo Boufford, I'm the vice chair of the Public Health and Health Planning Council and the chair of the Public Health Committee. And on behalf of John Rugge, my colleague who is chair of the Health Planning Committee, I want to welcome everyone to this joint meeting of public health and health planning committees. The council under the leadership of Jeff Kraut our chair, began its formal work last month and we had wanted to plan a series of sort of committee meetings, if you will, learning sessions to add content and opportunities for discussion among council members of both the COVID pandemic, which obviously has been one of the greatest challenges to the health care and public health system in many of our careers or lifetimes. And sort of use the council framework as a platform for discussion, hopefully problem solving that can contribute to future plans going forward. So these meetings of the Public Health and Health Planning Committee are really an effort to complement what may be more visible conversations going on within the hospital industry, with the governor's office, really looking at how to learn from the amazing work done by by the hospital industry, by the frontline health workers in managing this crisis and really almost being pioneers in the clinical care of these huge numbers of patients that's informing the rest of what's going on around the country now, I think. And really use our sessions as a chance to hear from the experiences of perhaps less visible, but we feel like even as certainly as important sectors of voice, the healthcare and the public health components of the health system in New York state, and that is the primary care sector and our public health leadership across the state. So today, sessions are the beginning of what we hope may be a series that would really explore these issues and other issues going forward. And our panelists have been asked to really reflect on the lessons learned in their sector and their own experience in the COVID epidemic, obviously, and now and the sort of settling down, but perhaps ongoing engagement with COVID in their sector and how those learnings could be applied to assuring that primary care and public health are the strongest possible participants in potentially preparation for future pandemics and certainly in informing changes in the broader health care system in New York State going forward. So today, there are three sessions to this morning on primary care that John Rugge will chair and obviously introduce. And then we'll have a lunch break from 12:15 to 1:00 and come back for 1:00 to 2:30 for a public health panel, which I'll chair. The format for each of the sessions, they are ninety minute sessions.

Jo Boufford Each of the panelists will has been asked to make a brief presentation, addressing some questions as sort of their experience, what they learned and how it might be applicable. Then the sessions will be open to questions from the council only. The sessions are being broadcast publicly, but for limitations in time and logistics, we're inviting the public to send written messages and send comments and all of those will be part of the formal record of this meeting.

Jo Boufford All of these meetings are being recorded and our plan is to identify themes that emerge from the panels that could inform future activities of the council, future directions in New York state health policy as we go forward. And we hope to have those themes identified in the next, definitely by September when we all sort of get back to work. The panel today, the three panels today, we have one planned for next Wednesday, the 19th. It's been preliminarily posted on innovation, integrated health systems to see how health systems, certain health systems in the state have been able to integrate care across these sectors, which will be really important going forward. And what we hope, and John and I hope that the things that we wanted, we were sort of recalling that the Public Health Committee and the Health Planning Committee actually started doing joint meetings almost a decade ago, I hate to say, eight years, seven separate years ago. To really kind introduce more broadly the conversation in New York state about population health and prevention and we've been trying to continue that conversation. I think we both hope that this session, the one next week and potentially future ones can serve the council to provide information, learning and opportunity for the council to take on and participate actively on important changes in the system going forward. So with that said, let me turn it over to John for the morning's activities John.

John Rugge I will be brief.

John Rugge As Jo indicates, this committee has certainly been occasioned by our once in a lifetime experience in the pandemic and I think that this presents both challenges for us to meet the needs of our patients and our communities, but also opportunities in terms of both preparing for future crises and also hopefully for improving the delivery health care generally.

John Rugge The council, as an opportunity to survey and perhaps showcase some of the efforts going on, which are really representative of what's going across the entire system. With regard to primary care, I have a prejudice and that is that it is certainly the case that we have a diversity of ways of providing primary care and that that serves our community and our state very well. We have FQUAC's, we have small independent practices, large corporate practices, hospital based systems and IPA's all striving for the same, for the same goals in terms of service. And what I've asked our panelists to do is to think kind of in two modes. One is how how is the price, how is COVID impacting and affecting and inspiring our efforts as primary care providers? And also, what kind of impact does this have on your particular sector. The way you're delivering care, so that we can do both the the larger themes and the granular themes in terms of how we need to proceed and how the state can help us. So with that each of the panels that has been provided three questions not to address in order or in any rigid way, but but to think of as they relate their own experience them and give us lessons to ponder. They being, what kind of needs and demands are you seeing from your communities and your patients? And how have you been able to respond to them? What is needed next to help us to give better care and not least what by way of public policy changes would be beneficial to the services we provide and the patients we serve? So not taking those in any particular order, but knowing that that's the intent of this of this session. With this, the first panel is really centered on the FQHC, federal qualified health center experience. These centers being especially funded and having a special responsibility for the underserved. So with that, we have in order Rose Duhan, as executive director of CHCANYS, the Community Health Center Association of New York State.

John Rugge In order is, next is, I may be getting out of order here, Mary Zelazny, presenting from the Finger Lakes as chief executive officer of the Finger Lakes Community Health Center.

John Rugge LaVonne Ansari, who's chief executive officer of the Community Health Center of Buffalo and also happens to be current chair of the Board of CHCANYS.

John Rugge Neil Calman, is the president and chief executive officer of the Institute of Family Health, both in the Hudson Valley and in the City of New York.

John Rugge So with that, we will turn this over to Rose for a starter in terms of considerations of how we're proceeding to address COVID and all the other needs of our communities.

Rose Duhan Good morning. Thank you, Dr. Rugge. And thank you to Dr. Boufford and Dr. Rugge for hosting this panel. And thank you to Chairman Kraut, who I don't see on my screen right now, but thank you to all of the members for having us this morning, myself and my co panelists to talk about primary care. As Dr. Rugge said, the first panel is focusing on federally qualified health centers or community health centers.

Rose Duhan And that committee, Health Care Association with New York State represents all of the 65 community health centers throughout New York State. Community health centers are by federal requirements located in medically underserved areas. So we serve in all parts of New York State, as is represented by our other panelists. We are located in urban areas, in New York City, Dr. Calman at the Institute serves the bureau, all of the boroughs of New York City, upstate urban areas, Dr. Ansari in Buffalo is represented urban areas, upstate and we have Dr. Mary Zelazny, who serves a very rural area of the Finger Lakes. Community health centers operate around eight hundred sites throughout the state. So we see and see about two point four million patients per year. So a really good proportion of a good chunk of the state population. About 60 percent of too many health center patients are covered by Medicaid or CHIP. So we see a pretty good chunk of the Medicaid population that is served by community health centers. Community health centers population have are uninsured at about three times the rate of other New Yorkers. So even though New York State has done a really tremendous job of expanding coverage to New Yorkers and we see a really high rate of insurance coverage of New Yorkers, community health centers have the uninsured rate of about 16 percent. So we see a number of patients and that's that's an average across the state. We see a number of patients that that do not have insurance. A number of patients who are presumably who are not eligible. We serve patients regardless of their insurance coverage, regardless of their income, regardless of their immigration status. About 90 percent of the patients are at or below 200 percent of the federal poverty level. So we do see really a predominantly low income population. Each community health center is governed by a board of directors that is comprised by a majority of the community health center patients that they serve in their communities. So the community health centers are very connected to the needs of those communities by design.

Rose Duhan Throughout the state community health center, patients are about 28 percent identify as Black, thirty seven percent identify as Hispanic or Latino and one third are best served in a language other than English. Community health centers provide primary care. Many can be health centers also provide dental care.

Rose Duhan You probably know that access to dental care is particularly challenging for individuals who are uninsured or have Medicaid coverage. So many of our health centers are the only site of sorts for dental care in in many communities throughout the state. Many health centers also provide vision services, behavioral health care, including mental health and substance use disorders, services.

Rose Duhan And community health centers also operate a number of school based health centers, operate in public housing sites and have a number of homeless, provide care to homeless both in in homeless shelters and through mobile outreach. And health centers also have a mandate to provide services to agricultural farm workers, I think Mary will talk a little bit about that. We have a number of sites, health centers in New York state that are designated to serve farm workers.

Rose Duhan So that's kind of an overview and our our expert panels will talk a bit more specifically about the populations that they serve. But just to talk briefly about the role of the FQHC seized during the COVID-19 pandemic. We saw health centers like other outpatient providers at the beginning of the beginning pandemic saw a precipitous drop in volume. Specifically, dental sites were closed except for emergency services with schools being closed, school based health centers, sites closed and as you all know, a lot of outpatient care. Anything that was primarily preventive or primary care was really looking to not have patients come in person onsite. So health centers were really able, so there was a precipitous drop in patient volume, which also associated with precipitous drop in revenue, as I think most of you are familiar with.

Rose Duhan And health centers were able to really quickly innovate and transition their care to a remote model that was really able to meet the needs of patients and also protect the patients and staff working at health centers to avoid, to really reduce in-person contact. Health centers maintained in an in-person presence in most of their communities, although that list was significantly reduced. But by the end of the end of April, two thirds of health center visits were being promote provided by virtual or remote care, forty percent of visits were by telephone and twenty three percent or about I guess twenty five percent were with an audio visual component. So the forty percent by telephone, I think really is an indication of the challenges for this type of Zoom, that I think a lot of us are so comfortable with and familiar with. But many of the patients served by community health centers face barriers in terms of getting that, having that access to that that audio visual component. And the telephone was really a critical source of access to care for many patients. And as our the our CMO who works with us said, it is amazing how much care you can provide to patients by telephone. I know there's a lot of discussion about that, but for many communities having access to care through telephone is an issue of equity.

Rose Duhan Many communities, there's limited broadband health. A lot of patients don't necessarily have a data plan on their phone that would accommodate the high value, the high amount data that's required for audio visual visits. So we really think that that telephone access was really an important way that health centers were able to remain in contact with their patients.

Rose Duhan For many of the patients, the health center serves a lot of chronic chronic diseases, so it really was important to maintain contact with those patients and ensure that there was ongoing care for those chronic conditions, especially during the pandemic, because of the adverse impact specifically on people who had perhaps underlying conditions. Throughout the pandemic, health centers were important site of testing for COVID-19 and community health centers partnered closely with public health

departments, both with the state operating testing sites, testing high volume testing sites on behalf of New York State, working closely with the State Department of Health, particularly again in communities where there was not otherwise access to drive up testing sites. So in a lot of our urban areas, drive up testing wasn't practical, nor was it practical for patients who don't drive. So in many of the New York City, a number of sites were stood up to offer walk up testing. It was through scheduled appointments, but that making testing broadly available to communities in communities that have were most adversely impacted by this pandemic. And community health centers were really critical to ensuring greater access to testing. Community health centers also partnered with public health departments throughout the state, throughout upstate and with New York City, to, again, the same wa make sure that testing was available for those communities who might not otherwise have access.

Rose Duhan I would say as we look forward to what might be a second surge in the fall or how we continue to go forward in this pandemic landscape.

Rose Duhan Maintaining remote care continues to be really an important issue for us to think about. How do we support that? How do we enable that? And at the same time, it's really important that health centers maintain an in-person presence as we prepare for the flu season. A lot of health centers are gearing up their flu vaccination clinics. And as we've seen a reduction in childhood immunization rates, health centers are a really critical point of access for in-person care for vaccinations that that obviously those can't be provided for. And the importance of continuing to manage individuals with chronic conditions.

Rose Duhan Obviously, that is also critical in terms of being prepared for the pandemic and reducing the need for for hospital care.

Rose Duhan Quickly looking to see if I missed any of my high points. So we'll talk, I'll talk a little bit more after the panel about some of the recommendations, but I'm going to turn it over to Mary Zelazny from Finger Lakes Community Health.

John Rugge Thank you, Rose. I forgot to mention the plan here is to have every speaker go for twelve minutes or so, ten or fifteen minutes, leaving time for questions, commentary by members of the council and others, one another.

John Rugge If there's anything very pressing, people can always raise their hand to interject. With that, Mary Zelazny. How are things in the Finger Lakes?

Mary Zelazny Thank you for the opportunity to speak there. They're good, you know, we're all doing our best to do what we can to get through this pandemic. I'm going to talk a little bit about my organization, but also I want to touch as well on how we have all use telehealth to really try to reach out to patients in this pandemic because it's been a critical tool for us. So Finger Lakes Community Health, we serve the Finger Lakes region pretty much between Rochester and Syracuse from this the the the Lake Ontario down to the Pennsylvania border. It's a very heavily agricultural region that has the Finger Lakes that run on North and South and there's no bridges, as you all know. So it's a very challenging area to provide services because you have to get around the lakes and there's there's very little transportation options for folks out in our area. And, of course, a lot of the specialty care providers are in the bigger urban sites. So we have to figure out how to connect with all those and get our patients to where they need to be. We have eight health centers across the region that I just described, and we are one of seventeen migrant outreach programs across the United States, which means that we use some of our federal money

to provide access to care for farmworkers in 42 counties of New York State by having contracts with private physicians, hospitals, labs, specialists, dental sites. So that farm workers that are not near a migrant designated health center can still access care. So we serve about twenty nine thousand patients in 2019, with about a third of those, almost a third of those being farm workers. We have about two hundred twenty people on staff right now and about half of them are bilingual by cultural due to the needs of our patients. What's been interesting about us as a community health center in a very rural conservative part of New York State is that 64 percent of our patients want to be seen in a language other than English, and almost all of them are from populations of color. Forty five percent of our patients have Medicaid and 42 percent of our patients are uninsured, which is, of course, a real challenge for us, not so much in terms of our primary care services, but when you have to refer those patients out to other entities, you know, specialist hospitals, if they need any kind of services, that's a real challenge for us. So during the pandemic, we decided day one, we would maintain all of our sites would stay open. We would continue to provide care. We had been doing telehealth for a long, long time. So this was not a big lift for us, for our staff. The one reduction that we had to put in place was, of course, with dental services. So we opened up for emergency services, only for dental so that we could try to keep people out of the emergency rooms because we really wanted the hospitals to be able to focus on COVID. And so that was a pretty logical option for us. We continue to see patients in person, which was a little challenging, of course, you know, some of the PPE was a huge issue for us, but we really needed to get our patients and continue to get them seen not only for COVID, but for chronic care, well child visits, immunizations, all those things that that people need to continue regardless of an epic pandemic. So our behavioral health services, of course, switched, you know, from mostly in-person. We are doing some virtual, but they converted all over to virtual, which was great because our patients, we found out the patients like that better and really had a much higher show rate, if you will, through those visits. And it continues to this day. And we we plan to continue that ongoing to offer that to our patients as we can now in New York State, so we're really happy about that. Of course, a lot of our patients don't have access to broadband. We're in a very rural part of New York State. You know, there's no money to be made getting broadband to these little tiny hamlets. And so there's a real divide here that we are constantly challenged with. But we were able to use telephone as we needed to for our patients. We set up all of our sites as drive through testing sites the first week that COVID hit both for symptomatic patients and asymptomatic patients, because a lot of people were concerned. And we had access to the federal portal to get uninsured patients covered for those COVID tests if they didn't have insurance. We also had set up due to requests from public health and from the farmer's community. We set up several provider teams that would team up with community health workers that were bilingual by cultural. And we had gone out to farm worker housing sites and farms and continue to do so to test farm workers that are coming into the region because we're in the middle of our harvest season.

Mary Zelazny So we have a lot of farm workers coming in from other states. And as you all know, particularly Florida, Georgia, South Carolina, where there's a heavy presence of COVID, that's where these folks are coming from and here to New York to work. And we have seen an increase in positive COVID tests in the farm community. It's a real challenge for everybody because public health doesn't have enough bandwidth to be able to handle some of some of the cases because you don't get one case, you get like five or ten, so it's a it's a real challenge. So we provide, you know, all the services that most community health centers provide and continue to do that through COVID as best we can. We've been very fortunate in that our model of care has always included reaching out to different populations that we serve. We go into jails, we go to head start sites, we go into migrant

summer school programs, we go into county jails, we go to housing sites. And that model of care has really helped us manage some of our patient demands through the COVID experience. And we have a very heavy investment in care management, which is critical for our patients. So for telehealth, you know, we we were invested in telehealth and we understood that telehealth was critical. But what it also allowed us to do during COVID is to provide access to care for our patients right away. You know, we just switched over and it was the biggest challenge we had was was trying to get our patients to understand how to use their phones to access their providers. And so we we converted a lot of our patient navigators to help patients prior to a visit to make sure that they had the right platform on their phone, the app and how to use it and how to work. Sort of a telehealth etiquette, if you will, for our patients so that they could understand how to get the most out of their visit with their provider.

Mary Zelazny But what really has helped us pre COVID and during COVID is that that, you know, telehealth technologies and the state put a lot of great exceptions in place for some of the rules, which is helpful. But it allows us to reach out to partners, to hospitals, systems that we need to access specialists. It allows our providers to be able to create great relationships with experts. My nurse practitioners and PA's, who we have out in our rural health centers now have really upped their skill set because they're continually speaking to the best specialists across New York State about mutual patients. So it's been a real game changer for us in terms of recruitment, retention of our providers, but also their skill sets. And then, of course, and with that, with COVID being able to switch quickly to seeing our patients at their homes or wherever they may find themselves has allowed us to can continue to care for chronic disease and all those things so that we've been able to really maintain some of their health outcomes. The other thing we did during COVID, which was really critical, we had some providers that weren't as comfortable as others with their telehealth usage. So what we did is we took super users and every site had either one or two super users with telehealth placed with our providers so that they had a lifeline, if you will, with them at all times in case the technology went down. Something happened on the patient and they could talk the patients you had to fix. Maybe they, you know, all of a sudden their sound went or whatever. So it was a really great practice to get those providers better able to handle a visit through telehealth, because we want them to be able to not focus so much on the technology side of it, but on the patient interaction. So that was a great tool that we used for our providers. You know and so the FQHC through CHCANYS, our primary care association. We really tried to up all of the FQHC's game, if you will, in terms of telehealth, because, you know, a lot of FQHC bases across the state were starting to learn how to increase their telehealth capabilities because of the new regulations that the Department of Health has allowed us to have in terms of billing, et cetera, for instance, that a patient could be at home or we could still bill for the visit and see them pre COVID. So we are really trying to up our game and CHCANYS was able to provide a lot of trainings and technical help for those FQHC that all of a sudden in one week had to go from no telehealth to all telehealth in order to continue to serve our communities. So that was a real help for all of us, but as we continue down this road, you know, we had some challenges, including, you know, how do you teach patients to use this technology? Because we consider telehealth at our organization and I know many of the FQHC's consider this a long term investment because this is a new model of care that is not going to go away post COVID. We all have to learn to up our game in terms of telehealth because it's a way for us to sustain our practices. We also have to get providers more comfortable with technology. We still have some providers that are not real comfortable with this. And as you have all seen, the number of telehealth visits now that we've kind of found a normalization within COVID, the number of telehealth visits being recorded has gone down. And I believe that some of this is probably because we haven't

been really able to have the time to build a successful base for all of our telehealth work that includes, you know, the right policies and procedures. How do you do emergency planning? You know, what happens if you're talking to a patient for a mental health visit and they all of a sudden go into crisis? You know, what are your emergency plans to make sure that that patient has someone to reach out to them when you're maybe two hours away the provider from the patient? So we've really tried to work with other FQHC's based on our own experiences to help them understand how they have to create a really strong basis for their telehealth work.

Mary Zelazny Because, as I said, this is not going away. This won't be the last pandemic that we have. And particularly as younger generations come up, tis is how they want their health care. So we need to be prepared for that.

Mary Zelazny So, you know, a couple of the things I just want to point out that I think that is really important for the post pandemic support for this innovation is that we need to really expand the list of print practitioners that that can be allowed to provide this kind of care via technology.

Mary Zelazny This is critical to our patients and particularly rural communities. We just don't have access to a lot of providers unless we use technology. But I would also argue in urban centers, it's also critical. You know, there's a lot of the same issues. We also need to make sure that we can continue to use technology to provide those visits that don't need to have a provider touch necessarily. It also provides for having an RN at a particular site and then having maybe a patient walks in. If there's an hour around there, they can tell a present to a provider from another site. It allows for access to care, which we know is a way for us to provide better health outcomes. We also have to invest in our workforce. You know, they need to understand how technology impacts health care and how it can really be a great tool in our toolbox, if you will, to provide robust care in all different forms. And particularly for people that can't get to a health center site, health care provider. It's just really critical we need to provide that support. And then, of course, for payment reform, we really have to continue. You know, a lot of great things have been put in place through the COVID pandemic, and they need to continue. We need to be able to be reimbursed on par with in-person visits. That's really important because it's all about the quality of care. And as we move into more value based payment arrangements, it shouldn't make a difference how we see the patients. It should be, you know, really be about our quality, how our quality metrics, how are the patients getting better. It shouldn't matter how we get them better. It's a fact that they need to be in a better place. We also want to think about looking at capitated alternative payment models that might eliminate this. You know how we continually get paid right now and a fee for service world of a visit and we did this and that is counting what we did with the patient. Again, it goes back to quality of care and how we can improve that care. You know, COVID has given us an opportunity across the the community health center after I see program to really look at how innovative we can be because we've had to to really focus on how technology can work for us. And we continue to go down that road and I think be a model of how the future will look for primary care. I thank you for that opportunity and I entertain any questions.

John Rugge A brief pause. Everybody taking a deep breath.

John Rugge Most what we'll do is be moving along. But I've already got a couple of people, at least one person with some questions coming later, which we'll be sure to get to.

John Rugge With that, LaVonne, are you there?

LaVonne Ansari Yes. Yes, I am.

John Rugge The floor or the screen is yours.

LaVonne Ansari Good morning, everybody. I want to thank Dr. Rugge and the Public Health and the Health Planning Council for having me this morning to talk with you about COVID lessons and opportunities. And I'm going to come from the perspective of the social determinants of health and racism. My health center actually sits is located at area nine counties. And we geographically, boundaries of Lake Erie on the west and Lake Ontario in the North. And also the Eastern boundaries of our zip codes on the east side of Buffalo in Cheektowaga and the southern boundaries in south Buffalo. And in twenty nineteen, for the past five years, Buffalo has been a hub of regions that is ranked one of the poorest of the hundred largest cities in the nation. Aand also Niagara Falls, well, we also have a size, the second urban poor, the poor communities. The other thing is that our poverty levels are pretty much what Rose has described, we have 44 percent income this fall below twenty two hundred percent of federal poverty level. And we had twenty four percent of the population lives below the poverty level. We also need to know just recently that Buffalo and region is the six most segregated metropolitan area in the country. We service about 21,000 patients and more than 70 percent of them are African-American, five percent of Asian refugees, seven percent have translation services. And more notably, that 44 percent of our families are below, again, 200 percent of the property and Medicaid is our predominant insurer. We also have a homeless population. We just like every other health center, we have internal medicine, family medicine, pediatrics, dental care, HIV testing behavior, health telemedicine, psychiatry, physical therapy. And one of the things that we experience with this COVID, it is that we sit in Erie County or in Buffalo and the highest confirmed cases in the county. So one of the things that was very striking for us and what I had to do a lot of research very quickly. And one of the one of my favorite scholars is Dr David Williams, he's a sociologist out of out of Harvard and he teaches Department of Social and Behavioral Health. And his works talks about the social factors of health. And one of the comments he had he makes is when we think of health, we think about medical care, access to care and quality of care that we receive, but his research and the research shows that where we play, live, learn and work have more to do with our health than going to the doctor, which what we found is very true in this COVID pandemic. And he charges that we need to think of health and promote health care based on the factors where we spend most of our time and opportunities. And what are those barriers and spaces where we have these where our social determinants of health? So just recently in July of 2020 in The Washington Post, racism, they had a whole article of racism as a public health emergency. And I don't think we are addressing it as such. So, my personal experience, we discovered that during this pandemic, that this Healthy People 2020 areas that we've been working on for years, we're all impacted at the same time. It was very continuous it's impacting indefinitely. So, as FQHC's, we had to quickly particularly I'm, I can't speak for my colleagues, but I can speak for some of us that we had to address all of these issues at once in a very crisis approach. So as we begin to look at these social determinants of health, what we found in this pandemic, and this is what happens, particularly those of us of color, is that we have we lost all control of our lives when all of those systems hit at one time and broke down for us. So, for instance, the economic stability I have right now, homeless employees. I'm trying to keep them employed through this pandemic and they're homeless. That's one fact, but it's very real. The second part, as you know, that education system, everything was shut down, so they had no child care. Then let's talk about health care briefly. As we already know, what we

experienced predominately during this is that if you looked at looked at centering around the Black patients, there were for. The field we look at full humanity in their medical encounters should be a clinical imperative, but that's not what happens with those of us of color. Instead, whether we're conscious of it or not, we we we sort of a race all out full humanity looking at the patient and replace it with the stereotypes of institutional practices that's masked as medical procedures and criteria. And I'll give you one quick story. My girlfriend's son, who started four years old, had COVID maybe three months before he gets sick again. He's a chronic asthmatic and he gets pneumonia. He goes to the first hospital, this is all within a five day span. He goes to the hospital. The first hospital says, can't do nothing for you, got to go home. He goes home for a couple more days, he's getting sicker. He goes to the second hospital. Second hospital says, can't do anything for you, got to go home. The third hospital. The third time his mother calls me. She text me in the middle of night and I didn't see the text the next morning, she says he's just got a hospital system because he was in the emergency room. I said, well, I'll call him to see how he's doing. I call him. He is so sick that can barely hear him because he's coughing profusely. I call one of my Docs. I said, can you telehealth immediately? She telehealth's and he's flat out into bed. So this is one of the great things about telehealth.

LaVonne Ansari You can see the people's homes and how they're living.

LaVonne Ansari Without the patient even knowing that you're seeing of the surroundings. So he's flat on the bed, can't breathe. We tell him call nine one one. We send him to nine one one. We talked to the attendant, the attendant says, I'll take care of it. This is the third hospital. He gets there. Guess what? The attendant has switched shifts. The new attendant said can't take you, you don't meet the criteria. This is the third hospital that's getting ready to send him home. By this time, this is a Friday. We know based on what we're looking at, the his lungs probably will collapse within hours. Had they sent him home, we had to fight to keep him there. And they want to put him in observation. Put him there, we're going to have him stabilized. They make a long story short, we get him stable. They keep him for three days. And I tell you this story because you can't have three hospitals that's going to turn them away. He's a thirty year old Black man, thirty-four year old Black man that he had no longer had COVID, but because probably they saw the criteria. The first diagnosis is COVID, they sent him home. So all these near misses. This is a class a very good example of how when we think we're looking at them from a clinical perspective in a comprehensive way, we're actually not looking at them based on the criteria that we're that we're seeing. So that was a near miss and thank God that he's he is he's alive. So the second part, the fourth part is we talk about neighborhoods. We have we have a farmer's market. And as you know, as people are unemployed, they don't have any money and they're not getting, therefore, they can't have any food. So as a health center, we have a farmer's market every week for our patients. And one of the and the fifth one that we're looking at, the social trauma itself from the Healthy People, 2020 is the social and community environments that our patients are in. Now based, just COVID is here. However, the communities in which we're living in that have crime and not a safe spaces are still continuing. Just recently when my employees grandsons got murdered two weeks ago. So all those things are happening at once. So one of the things that we really have to address and as I'm not a physician, I'm a PhD in sociology. One of the things that we don't address well and I think we need to address is that the biological reactions to stress. Because we know that in normal situations, the stress, your stress will turn on and off. And the African-American community, those of us that are dealing with racism and discrimination, that that stress the fact it does not turn off. So what happens is it just keeps eating away at our systems. And that's why we're more prone to chronic diseases. And that's why COVID would hit us very hard, that's one of the reasons. And there's scientific

research that discusses that. So one of the opportunities I think we have in this in this time is that.

LaVonne Ansari The opportunities to have these very discussions on race, racism and the impact on our systems.

LaVonne Ansari Mary talked about the telehealth and virtual services, so we don't really need to, I don't really discuss that. But what I can tell you is that when we started with COVID, we started connecting with other agencies in our communities that we have not formally connected with normally. And so we that's one of the great things about COVID. It brought all of us together in ways that we would have not really built relationships. The other thing I found out and discussing with some of the providers is that access doesn't give you connectivity.

LaVonne Ansari And there's an assumption that.

LaVonne Ansari Giving people of color, all of us having access, gives us the connectivity to the system. It doesn't, because if we had the connectivity, then we will understand some of the humanity and the comprehensive humanity approach that we need to service some of our patients in our communities. So one of the other things that we've done in the health center, in particular when this crisis occurred, I put a COVID team together of my young providers. That was a very integrated approach because as FQHCs, we do have a very comprehensive, integrated group of staff. So my dentist, PT, internal medicine, pediatrics, family med, we all meet once a week and since this COVID and we started figuring out our own treatment and now we have started doing our own research and we have we do have one publication that we just published. So we're really excited about that. Because one hears the most critical thing that we see, because we have a predominantly African-American communities of color, which is where we need the most studying. We said that, you know what? We need to study ourselves. So we started collecting data and we will continue this research. So that disciplinary team approach is very, very is very, very critical and became very obvious during this during this crisis.

LaVonne Ansari So lessons learned. We need to look at race matters.

LaVonne Ansari We have to look at racism as a factor to our public health. And it is an issue and it is measurable. And Dr. William Davis has some actual tools that we can use, which we're going to start implementing in some of our own templates of measuring our patients stress levels and how it impacts their health.

LaVonne Ansari I think that.

LaVonne Ansari Anti-Racism action plan and health care and approach to that would acknowledge solving some of the failings that we have in our own system so that we can do better in serving our patients. I will say that the killing of Mr. George Floyd death raised the consciousness of racism in law enforcement. However, if we look at our own data, we work in an industry that every seven minutes African-Americans die prematurely in this country.

LaVonne Ansari And two hundred, that means two hundred of us are dying a day.

LaVonne Ansari We know that we wouldn't die if the health of both African-Americans or those of color and whites were equal. So we have an opportunity to make those changes.

And I'm really excited about having having to to do that work and layer it with looking through the lenses of some of the work.

LaVonne Ansari Dr. Rugge, you need me stop?

John Rugge We're trying to roll along, so there's plenty of time for discussion.

LaVonne Ansari Okay.

John Rugge But thank you, LaVonne, very much.

John Rugge A brief pause. Two deep breaths. And moving on to Dr. Calman and the other part of New York State.

Neil Calman Yeah. The part that made the news by getting hit first. So tell you a little bit about the institute as requested. I was one of the co-founders in nineteen eighty five. We got our first federal grant as a federally qualified health center in 98. So, ah, we operate now on a budget of one hundred and forty five million dollars. Nine million of that comes from our federal grant. And ninety two other grants and contracts total about 40 million that we get from others from those other sources. And the rest comes from patient care. Most of our grants are for things that we're doing out in the community, community based health promotion around diabetes, heart disease, nutrition and social determinants. And I think that I think I told John when he first called me about this that I could be on the public health panel as well as the primary care panel, because I think so many of us do so much in relationship to public health outside of our health centers. So we now operate 34 locations; Manhattan, Bronx, one in Brooklyn and five in the mid Hudson region, Kingston, New Paltz, Hyde Park, Ellenville and Port Ewen. We have 18 Full-Time Health Centers that are, you know, the normal things that you would expect health centers to have, as well as six school based health centers, two centers that focus on care for people who are developmentally disabled, seven homeless health care sites and a WIC program, 52 dental chairs and eight locations, dentistry is about twelve percent of all of our visits, about seventy five thousand visits a year. Behavioral health in all of our centers represents about a quarter of our visits, about one hundred and fifty five thousand visits a year. And totally we do six hundred fifty thousand visits across those three were almost exclusively a family medicine based in our primary care model. I'm a family doctor and eighty five of our 92 docs are family doctors. So, and behavioral health we have one hundred and twenty five providers, psychiatrists and mental health counselors and social workers. We also have, I think, sixty three dentists now. So there's a few unusual things about the Institute for Family Health. One is we do an enormous amount of training. We actually sponsor three family medicine residency training programs. One in the Mid Hudson area and two in New York City with 70 family medicine residents. We have a family nurse practitioner residency program and we host the entire Mt. Sinai General Dental and pediatric residencies in our program. So from the very beginning of the institute, you know, we set out not to just be a consumer of health care providers, but a producer as well. We have four fellowship programs, one in clinical research, one in women's health, one in integrative care, and one in nurse practice. And we have over one hundred people doing care management. Some of them, about twenty-five of them actually are out in people's homes. The rest are doing care management in the facilities and and telephonically. And another unique aspect is that we actually set out in the very beginning that we that our doctors would care for people who are in the hospital. That I was felt like when people needed their doctors the most were when they were the sickest, and so that we should be able to do that as well. So our doctors have privileges at Mount Sinai, in New York City, in the Health Alliance or

the Hudson Valley in Kingston and in Ellenville Regional Hospital. And we run Family Medicine Services in all three of those locations. And our family doctors deliver babies in both at Mt. Sinai and Health Alliance, not all of them, but about fifteen of them now are still doing obstetrics.

Neil Calman So that's kind of the background. COVID, unbearably difficult. Just having to put down some notes for this, I felt traumatized all over again. I mean, it's just, I guess, uncertainty. So I haven't felt as this incompetent, I think, since my first year of medical school on my first clinical rotation. You know, we were facing something that we had no idea what it was, where it was going, what we needed to do, and things were constantly changing. We started out by having eight a.m. meetings with our forty medical directors and training directors every single morning, seven days a week and eight p.m. meetings with our twenty two person management team every single night at eight o'clock, seven days a week. And did that probably through the first two months of the pandemic. And it was just that's how quickly things were changing, both in the procedures, in what people needed in trying to, you know, manage all of these centers and to figure out what to do with personnel. We ended up furloughing about 250 of our fourteen hundred employees, which was absolutely heartbreaking.

Neil Calman And I did it with, you know, just take it in.

Neil Calman You know, against all of our better judgment and all an all of the things that we believe then about trying to keep people working and everything like that, the fact that we were sending people home was just, yeah, was really heartbreaking. And then there was this incredibly diverse reactions of staff and patients. I mean, we had staff basically said, oh, this is B.S., you know and it's really nothing. And then we had staff who were so terrified that after they saw what was happening, they just absolutely refused to come to work. And we had patients with the same reaction. You know, they would call up and they'd say, oh, you guys are like closing the, you know, a few of these sites. Why? That's ridiculous. You know, there's nothing really happening here. And then we had patients who just absolutely, you know, were calling, canceling, cancelling their appointments by the thousands. And then, of course, it wasn't helped by the politicalization of the information we were getting. So we really people just really had no idea where things were going. And then, you know, probably worst of all, people were being told to stay home. And primary care was really in this crazy situation where the people who with really severe, uncontrolled chronic illness, who needed to be seen the most for the people most at risk if they went out especially to take public transportation or come to the centers. And so, you know, we were incredibly well equipped, equipped to do telehealth. Actually, Mary Zelazny got us started on it a number of years ago. Our psychiatrist, we're doing telehealth with her with some of her patients in the Finger Lakes. But also because we had fully implemented administrative, financial and all health records on EPIK since 2002. So we have an extraordinary group of health information technology, people who've been working with us some since our original epic implementation.

Neil Calman And they were able to literally build all of the templates and all of the all the things that we needed to be able to book appointments remotely and to operate telehealth. Literally within two weeks, we were seeing as many patients through telehealth as we were seeing in person previously. And about 90 and ninety four percent of all of our visits converted to telehealth.

Neil Calman So I was asked to talk a little bit about the behavioral health aspect.

Neil Calman So first, just a huge shout out to the Office of Mental Health. OMH stepped up almost instantly when when we when they realized what was happening. And they did a fabulous job of getting out information that wherever the provider was, wherever the patient was, if the visit was documented the way it was supposed to be, they would pay us at our regular PPS rate, the rate that's guaranteed to us under the prospective payment system by the federal government established by HERSA. And that covers all Medicaid encounters. They were very clear that they were really agnostic as to whether those visits were going to be done in person on a video call or even just by phone. They would pay the same rate.

Neil Calman What that did was it just created this huge breath of of clean air for us to be able to move all of our telehealth media, all of our behavioral health immediately to telehealth. And then I think it's really important to realize that our patients loved this. I mean, you know, Mary said this before, but it's amazing the no show rate, our no show rate dropped by about fifteen percent. We now seventy seven percent of our people who are scheduled for telehealth visits are available at the time they're supposed to be on telehealth, which was which is a huge improvement from what happened in person. And then think about coverage. You know, somebody calls in and they can't do their visits, any of our providers, Hudson Valley, New York City, wherever they are, because we share an integrated health record, any of our providers can step in and take over those patients. So, you know, we always have a few people on vacation or people who call in or whatever. And we used to have to cancel those appointments. We don't cancel them anymore. They're just immediately reassigned to other providers to fill in for their no show visits. So there's a huge increase in efficiency there as well. And the patients love it. I mean, imagine, you know, they want to see their therapist and they have a 9:00 appointment. They take their cup of coffee. They walk over their computer at 9:00 they're on.

Neil Calman At nine forty five, they're done. And they go back to doing what they were doing. No transportation, no waiting and waiting rooms. It's all, you know, anonymous. They're not sitting in a waiting room with other people with all the stigma that might be attached to that and everything else. And so I think, you know, thinking about policy implications, I don't think we're ever going back to the way things were. You know, our visit volume now of behavioral health is twenty five percent greater than it was before the before the pandemic with the same number of staff people. So improved efficiencies. I asked for a couple of people to send me some some vignettes. I'm just going to read you one that I got from one of our LCSW used in the Bronx. She said, I have a patient who's immune compromised, was frequently too ill to attend to her in-person appointments even before the public health crisis. I met with her during the first week of our transition to remote care over the phone and she said this is the best thing that's happened since she no longer had to leave her home to receive the care she needed over the subsequent months.

Neil Calman The patient has been able to attend all of her scheduled therapy appointments and even felt good enough to engage in some small amount of physical exercise with me while at home during one of our sessions.

Neil Calman So, I mean, there's a lot of a lot of interesting things about telehealth for behavioral health. You know, obviously, it's it's not working for dental. It didn't work for dental. And it worked well for primary care, but still with this huge need for people to still be coming in in person. And so I think we'll always be doing a mixture of this and primary care. I think we'll always we're going to keep the majority of our visits, telehealth visits in behavioral health. And again, with a savings there of physical space that has been

allocated that will probably be reprogrammed for primary for additional primary care space in at least a few of our centers. So just some thoughts to leave with in relationship to health policy.

Neil Calman And, you know, I'll keep my comments short and the mode of seeing the patient, whether it's face to face or video or telephone, should be dependent on what's in the best interest of the patient and what the patients are capable of doing, travelling, using video or whatever. You know, we need a payment system that's agnostic to the way in which we see people. And then partially, you know, one of the misconceptions about telehealth is that it doesn't require support staff. And I will tell you that all through this, our support staff was doing all of the things that we needed to do to support telehealth, which was, you know, calling people ahead of time, trying to teach them how to get on video, setting up appointments, dealing with no show. And the all of the things that that the support staff do anyway. And for the primary care people, you know, trying to get people who at home blood pressure cuffs to report in their BP so that they could be put into the system before the providers had to sit and go through, you know, and enter the last six blood pressures and everything like that.

Neil Calman There's a lot of work for support staff to do so, that thinking that, you know, we can pay a lot less because people don't have all of this other stuff to do is really 80 percent of of all of the support staff that were that were needed for face to face care is still needed for telehealth. And also for follow ups and to call people back with, you know, with their results and other stuff like that. We definitely should have some good clinical research put in place to find out, especially around behavioral health, whether there's a difference in outcomes between people who are, you know, being seen face to face, people who are being seen through telehealth exclusively, and people who are sort of getting a mix of both. And I think, you know, we really have to remember that HQHCQ's are really a special breed. I mean, whether you think about the fact that where else can you go in the health care system where you can get primary and preventive care? Behavioral health care and oral health care, as well as community, all the community outreach and health promotion. And where people, many of us in the health center community are teaching the next generation of providers. And also, where you know, we need to be sustainably reimbursed for what we do. You know, maybe a capitated model that's agnostic to how the encounter takes place would be the best of all worlds. But, you know, I don't think there's another place in the health care system right now where you can get all of those things done. Integrating all of those types of care in one location, in a community governed system whose mission is to provide care where no one is turned away. And we need to find a way to support that in both administratively through policy and also economically. I'll end there.

John Rugge Thank you, Neil. A few concluding remarks, we'll try to leave time for questions. Rose, I think a couple of ideas about connections to public health.

Rose Duhan Sure, I'll just talk. I'll talk briefly about some of the looking forward things that we've identified as we've thought about what it's happened throughout the pandemic. I think rather than the lessons learned, I think it's more truth revealed. I think is what's come out of this. The racial disparities that we've seen in this pandemic are well known to many health centers. So it's not something new, but we are pleased that there's been a renewed focus on that as we think about what we're looking at the future. I think it is really important that we think about how is the health system system in general? Both the public health and the health care delivery system thinking about addressing institutional racism. What is the data that we're collecting? How are we measuring the impact? I think those are pieces that

really need to be integrated into the work that we do. We've also, again, not something new, but really has been highlighted the really critical interdependence of individual health and population health. We've seen that when individuals health is deteriorated, that that really shows up in the public, that the impact on public health, that really ensuring that access to primary care and ongoing preventive care is critical to support the work of public health and vice versa. So I would say that a strong public health infrastructure really requires a strong primary care infrastructure and we to ensure that our policies are supporting that primary care infrastructure. One really critical piece of that primary care infrastructure that that was touched on by Mary LaVonne and Neal is the importance of care management and really especially for vulnerable and poor communities of color and for low income communities that care management is not something that you're cured that you don't need. I think there's been a lot of focus by the Department of Health on the different types of care management programs that are funded through Medicaid. As I've said, we know health centers are a lot of patients that are not covered by Medicaid. So really having robust access to care management for the full population served is a critical part of supporting primary care and public health. It's also been touched on by by all three of the health centers thinking about new methods of reimbursement. You know, we all of our health centers talk about how many visits they do per year. Visits is something we talk about because it's something we can measure. It's easy to measure, but is that the right measure? So I think that and we've traditionally been reimbursed based on a visit. So as we've talked about different ways of delivering care, different models of what what constructs a visit, I think we need to think about reimbursement structures that support different ways of interacting with patients. And I think that a comprehensive model that's not tied to a specific specific encounter or a specific count that really supports different ways of interacting with patients based on the patient need, based on the resources that the patients have. And that can really, again, look at outcomes and trying to look at quality measures that are based on what the life quality for patients and not necessarily the number of visits. We also know that new thinking about workforce is needed. How do how do health care? How does health care delivery train workforce to adapt and adopt to new technologies? How do we ensure that providers are ready to provide remote care and not just assume that that's something that's that's absorbed? Again, it takes like support and a lot of thinking both about the personnel training and about the operational procedures as we've heard. As we think about schools reopening, I think we need to think about the partnership with public health, primary care and education. Will, as Neil said, there's many unknowns. There's a lot of unpredictable unpredictability, a lot of uncertainty more than usual in the environment. So the more that we can work together, that we can communicate and collaborate. Specifically in terms of health care, I think there needs to be a really robust planning effort and with primary care and public health. One of the things that we've learned is that the more preparation that we have, more planning, the more communication, the smoother that the better. We're prepared for an emergency. So I think that having some greater integration in emergency planning with primary care will really help us as we think about future pandemics, as it's been said. We don't think this is going to be the last pandemic that we see and perhaps even see another surge of COVID-19.

Rose Duhan And I would say that finally, I think that the Department of Health should. Would we it would serve all of us well to have an identified focus within the Department of Health on primary care. And I think that's something that's been a little bit challenging for us, is being able to really have that visibility for the role of primary care in the health care system and to have that identified place for the coordination with public health. So with that, I will turn it back to Dr. Rugge.

John Rugge And I'm looking to turn it over to the people on the screen.

John Rugge For one, Dr. Guiterrez had some thoughts about broadband and connecting to other agencies from the health care system.

Thank you, John. I was impressed with the comment that Dr. Ansari made regarding connectivity, not meaning communication, connectivities, technology, communications and art in my view point, I think that we don't need to, this has been tried before.

I can I am witness to the fact that communication is achieved in a place like Patagonia by using good cell signal and a person moving around with a van that goes to places in distant places to see people.

And it occurred to me that perhaps one way to achieve better connectivity is to look in to.

The available local, state and federal offices, schools, municipality soundboards, slightly farmers post offices that could arrange for broadband access for healthcare purposes to needy patients. Is that something that has been explored? That's a question. So I leave it there for discussion and whatever. Thank you.

I happen to know one health center in the Adirondacks that he has been having patients come to municipal parking lot so they can contain the broadband they need so they can get good care in that way.

Very weird, but it works.

Yeah, I'd like to comment on that. We've talked across all the FQHC's about, you know, how do we create telehealth rooms in a multitude of areas that would allow patients, regardless of what provider they were saying you would be able to go into these little like the old fashioned phone booth type things.

Or they could have broadband access to be able to communicate with their providers because it's a problem in so many areas, urban and rural.

So we've talked about that because there are access points across many of our communities. So if there's a way that we can have them all pitch in, if you will, and give patients access.

That would be a huge boon to allowing people to communicate with their providers.

Two quick comments. One is there is a statewide the statewide sort of governor's commission on building back better or whatever is a term of art, is that that Schmidt is chairing the chair of Google and others. And we've we've had some conversations with them and I've given them names of a lot of the people that are on the screen that are presenting today because they're really focused on a lot of the issues you raised around broad. They realize that telemedicine, telehealth broadband issue is huge. And the good news is they're being incredibly well staffed by people. They've seen the report that was done on broadband access statewide, et cetera, et cetera. So it's a if anybody wants to look up that commission and knows anybody on it. I've done that and talked to people that are on it and talk to the staff director to try to get. They said they were going to have some people come and speak to them just because their point of view needs to come from public health as well as primary care, not just the hospital industry. So it's a really important opportunity. And the good news is I think they're thinking about a lot of the

issues you raised, not all, but you can hear more, but a lot of them. I think the other the other thing I wanted to raise was about the I wanted to ask a question actually of the of the folks that presented. What's been the role of pharmacy and pharmacists in this during this period. What do you see their potential role being? I mean, because a lot of them obviously are getting into the we know this from discussions we had at their public health planning committee. It's been a year or two ago about putting primary care in pharmacies. You know, there you know, the efforts to connect it to primary care providers, the availability of broadband. I mean, all these issues, I just like to throw that question out and see if anybody wants to pick up on it. Have they been or are they interested? Have they been helpful? What could be done?

John Rugge Responses?

Before we go to the pharmacy question, I will note that Mary and I did have the opportunity to present to the blue ribbon commission and talk about the telehealth issue.

I wasn't sure they followed up any of it. That's great.

Yeah, thanks.

Dr. Rugge, I can comment on that. I'm not one of the current panelists coming up a little bit later, but we certainly have a bias for integrating these services right into primary care. So we heavily use our clinical pharmacists that we have on staff that CCP. And they were you know, we found them to be very, very beneficial throughout. But during the pandemic in particular, because they can have a telehealth visit with patients really struggling with their medication regimen, they can walk them through those issues, medication, reconciliation, when they're transitioning from hospital or other facility back home. And as was mentioned, I think, by LaVonne, the ability to just talk with a patient and say, just bring your bottle. Let's just read, you know, what you have there. Bring them all. I'll focus the camera on them. That's been really, really very important. So I think there's a huge role for integrating clinical pharmacy into the primary care practice.

I also have a clinical pharmacist that I just hired a few months ago, and she's been phenomenal with helping the providers, with helping with care coordination of the patient, particularly as they transition from the hospital back home. So it's it's it's needed.

And I don't think it's used enough, but it's a critical part of practicing and also doing this COVID.

We're finding that there's certain hypertensive meds that interact with this COVID that actually a lot of African-Americans are on that. Our research is looking at preliminary that thirteen times higher, if they were on this hypertensive med to be in the hospital. So it's been very helpful.

John Rugge Other questions? Members of the group? Members of the council? Harvey.

Harvey Yeah. Thank you, John. And a great presentation team. Wonderful to see you all and hear you all. The question that I have to and I guess the first is we've all on the other side. I've got us here in the state of the pandemic. We've had this incredible spike and we flattened the curve. And the consequence of that, I think, is that we have lower mortality rates, infection rates. But we all are anticipating at some point it's going to revisit the system and we visit the state in the fall. My first first question relates to the financial

sustainability of FQHC's throughout the state. And what, if anything, needs to be done to ensure that that that happens and continues that there's additional support? Because I think, as some of you have noted, at some point during the peak, there was this, a dime was down and revenues were off. They were also retrench and retrench retrenchment plans that needed to be activated and were activated. So what what do we do to stabilize if Turid sees across the state and what additional assistance need it? And then the second part of that is how how do we know what is needed from hospital partners and how is that working? And what do we expect to see from hospital partners in the future? What would be the ideal that involvement and contribution that we can should expect from our hospital partners?

I'll take a run at that, Harv.

I mean, so we know we lost. We lost about 15 million dollars in patient revenue, largely because for privately insured patients, Medicare patients and for primary care patients in on Medicaid, we weren't getting the same reimbursement as everybody else. So we were seeing the same. And if not more patients I'm seeing in quotes. But we were caring for as many, if not more patients in some cases, but getting less reimbursement, that's not sustainable. So there's that's got to be fixed. The system's got to be agnostic to to how people are seen. And that's got to be a decision made in the best interests of the patient and and the and and the ability of the patient to to to connect. To me, that's the most critical thing, because I think we we've made the transition and we can continue that transition, but the reimbursements got to support it. And right now, the reimbursement is not supporting it. So that's that's number one in terms of the hospitals. This has been a really strange we and we have really strong relationships with multiple hospitals and, you know, substantial contracts to do all kinds of things with the hospitals.

You know, contrary to what most people think, they're all the patients in the ICU they're going to bill for this, they're gonna make a lot of money. The hospitals and they basically lost a lot of money because a lot of the money comes from elective procedures and things like that. And those were basically on hold. And they're ambulatory care services, which are also very lucrative. We've suffered the same things that that we all suffered in terms of not having people there. I think the major if there if I had to pick one thing that the hospitals needed to do, it would be to go back to LeVon's statement. And that basically is. They need to open up their doors in a non-discriminatory way. And I mean all they're ambulatory services and all of their inpatient services so that they stop taking care of Medicaid patients in separate places, three separate systems, as they do for privately insured patients. We've been struggling with that, as FQHC's for decades. And until, you know, we we're talking about equity in access in in outcomes and people being able to get the same outcomes from the system. People of color and and and whites, that that's never going to happen if people don't get the same services. And so, you know, people are struggling for access to two clinics for their Medicaid patients. And meanwhile, that the hospitals continue to build up these amazing facilities for their faculty practices and their private practices, many of which most of which in that in the in the places that we're involved in, don't accept Medicaid at all and don't even accept Medicaid managed care and don't even accept Medicaid managed care in many cases from health first, which they are partial owners of. So it's it's a bizarre system. And we need to we need to eliminate that level of discrimination immediately. And I think that would provide our patients with great access, which would save us enormous amounts of time trying to struggle to get them into places that are all over, you know, the communities that we're in but aren't accessible to our patients because they have Medicaid coverage or Medicaid managed care or uninsured, even worse.

We at the risk of running over, but acknowledging that Jo and I spent twelve minutes at the beginning wasting time on the production material. So our question is coming up that I don't think we can miss. Let me run a little over, make stuff. Next session, just five minutes late and allow for running over.

You're on mute still.

Thank you so much and I really want to thank you and Dr. Boufford. Certainly thank Dr. Kraut for his continued support of these committees.

This is a wonderful session and I do have a number of questions, but I'm going to be patient and ask these later ones, some of them. But I would like if the persons who made the presentations, if they can at some point provide a report very brief to the committees that in fact focus on the pre COVID and the current pandemic in terms of five areas, access to care, impact on the social determinants of health. Impact on quality of care indicators, the stack on availability, particularly in a stack furloughs, particularly on health care disparities. The other thing that I would like them, if they can, to provide us some attack at every point on the fiscal impact from their agencies. I've heard some from some of them, I think would be useful for the committees to hear of this form across the board of the panel that we have. And lastly, I would really be interested in hearing if you had to choose, I'd say, to read top suggestions that you would have for the New York State Department of Health, given your experience. What would be those three top suggestions that you would suggest? Thank you.

Those are excellent. I'm sure Colleen will be our records and we'll send them out. Or if you would wish to send a memo. I think that's a great follow up to everything we're discussing and doing.

Dr. Calcut, we'll turn to you.

Thank you, John. And thank you and Jo for setting this up and to the panelists for a great presentation. I had a question about school health and what your programs are doing for the school year that is starting in the next few weeks given not all of the variation in how school districts are approaching it. Are you able to open your programs? Are they open in an abbreviated, truncated way? How was school health going to look like for your clinical programs starting in the next month?

So we're preparing to open when the schools open. You know, I think we're what we're concerned about is that we're gonna see a lot fewer patients and that's going to have a big revenue impact. And so we don't really know how to sustain that with the same resources. The school health programs lose money. Now, every single one of our sites loses money. It's really a public health contribution. I think most of us have the same experience. We're providing dental services and like for the schools. And, you know, you can't if people are going to be socially distanced, then they're going to spread the kids out over, you know, larger periods of time. I would guess that's going to mean we're going to need to cover larger periods of time and have fewer visits. So I don't know how we're gonna do that somehow. There needs to be some financial model for that that's going to work for us.

We will be using, we're working with the Buffalo public schools now and looking at our mobile unit, going to some of the schools to do testing and probably some of physicals with the mobile unit.

So we've been doing with our schools is trying. We've been setting up specific dates that is for kids to try to get the physicals done sooner rather than later, because normally those physicals go into the into September. And we've reached out to our schools that we serve and saying, let's get these kids in now. So we've held out special dates for them both at the schools and at our health centers so that these because we expect, you know, the he other shoe to drop and COVID to increase. So we really want to get to those kids, most importantly, to get their vaccines up to date, make sure they're up to date. We're also working with some of our school districts to provide a lot more access to care through telehealth, because that's a way that we can reach out to those kids, because, as Neil said, the rules around social distancing are impacting what how many kids we can have come down to a health center site within the school at any given day, and it's just not sustainable. So it's a real challenge. So we will be using telehealth to reach out to those two more students.

And another key planner for the activity, Ann Monroe. I think you have the final the final question for this panel.

Well, thank you, panel. I really feel you did a great job. And I want to echo Dr. Lawrence's point about what is the fiscal future look like. And I'd like you if you could, Rose, just comment briefly on the 340 B program, which is one of the major sources of kind of unrestricted money for FQHC's. And in the MRT2, that money has been determined to go directly to the state rather than to the FQHC's is with those pharmacies. And I'm wondering what CHCANYS plan is to to see if we can't get that money directly to the epicure seized with pharmacies. It would be a huge blow to many of you, I believe, if that money is swept by the state. Could you speak just a moment on that before we separate?

Sure. Absolutely. So the 340 B program is a program that allows safety net providers to to access savings through there, through pharmaceutical pharmacy services, purchase of drugs. And it's somewhat complicated and I'm sure we can have a whole session on that. But the proposed changes that Ann referenced that the state is moving forward with and Medicaid managed care program that would move that pharmacy benefit from managed care to fee for service, would essentially eliminate access to that 340 B program from Medicaid managed care. And the three point B program generates a significant amount of, as I said, unrestricted revenue that goes to the taking net providers. We calculate it for health centers in New York State that the value of that benefit to patients is about one hundred million dollars worth of services that are provided by health centers with support from from the 340 B program. So that the program goes away. That's a loss of direct services to those patients. Again, that's patients that have been at most adversely impacted by the pandemic. We've been advocating with the Department of Health talking about the importance of these programs. Again, there are a lot of services that are not otherwise funded. So as we're talking about some of the school based health center programs, how we're going to continue those, sustain that with the impact of the pandemic, with that care management that's been so critical during the pandemic to do more outreach to patients. All of those services are supported by the three point program. And so we've been working to really be specific with the Department of Health about those services and the volume of services. And what will happen, what the impact will be for patients and their communities. So I think that given the the challenges that have really been exacerbated during the pandemic that that revenue, which is really critical. And so thinking about that revenue going the way at this time as it's been raised by others with the other financial challenges that it brings, that's specific, that's devastating.

John Rugge This is a comment, at least two farmers to go manufacturers are taking some sneaky steps to subvert the three four to be program generally. And so, again, if it calling attention to two to the state, to be sure that really essential resources are not lost will be important. With that, knowing that there are any number of questions still to be asked we have not been able to get to. We want to thank our panelists and an offer for those contributions. A wonderful prologue for what's coming. I noticed the time is now 10:38, perhaps we could start at 10:50, instead of 10:45 and then we'll go five minutes over, if that is okay. I see Mark Foster has arrived. Welcome, Dr. Foster.

John Rugge And I know that time again is here someplace. And Jacqueline Delmonte, I had seen earlier, I think she'll be back, but we will we will retire for like ten minutes and give everybody a nature break and come right back, so.

Thanks, John.

John Rugge As present CEO of her Delmont Medical Care practice in the city and has a long experience being medical director and CMO, most recently with Sampson in the IPA world.

John Rugge Mark Foster is a MEDPED physician, internal medicine and pediatrics in Wappingers Falls.

John Rugge And likewise has had numerous experiences with GRIO's and IPA's and has decided to pull into a full engagement with with primary care.

John Rugge And will have a lot to tell us.

John Rugge Moving along, Joan Hayner is chief operating officer for Community Care Physicians, a large medical practice in the capital area, Albany and beyond, with lots of experience coming together to form this big group. And not least, but last is Dr. Tom McGinn, as deputy physician in chief at Northwell. Northwell is a modest, rather small practice, well, not too small, operating in New York, treating some something more than 20 percent of all the COVID cases in the state. So with that by way of introduction, we've had the same kind of discussion about talking generally about primary care, but looking specifically at the perspective of coming out the where you are and also looking at what spend the COVID experience, how we've been viewed or responded to our patients needs.

John Rugge What more needs to be done and how can evolving state policy help us?

John Rugge So with that Dr. Delmont. And once again, a reminder, we're trying to keep the discussions on the order of twelve minutes or so and start waving my hands when I get panicky.

John Rugge If we're starting to run over. Jacqueline.

Dr. Jacqueline Delmont Good morning, everybody, and thank you for the opportunity. I think I come to to this panel with two perspectives. One of, an independent physician that has been in practice for for more than twenty years. I'm an internist from Venezuela. And came to us about twenty something years ago and redid my training and opened my practices in the South shore of Long Island, where predominantly we take care of of Latino underserved communities, mostly insured by Medicaid. At some point I had an Article 28,

so I had to face a public health council also for adding services and want not. And part of the reason why, even though 70 percent of the patients that we see are Medicaid, we were able to remain viable was because we joined Somos IPA, of which now I'm the chief medical officer. And I think Somos is known also because of the participation as a PPS with incredible performance in terms of reduction of hospital admissions and utilization of the emergency room. Somos Community Care is comprised of twenty five hundred independent physicians, predominantly Latino and Asian, that care for those same communities that the physicians that look like the physicians. We're in for burrows of New York City and Nassau County. And I during the participation of all during the COVID pandemic, you know, we were there from the beginning. March 5th, we had a call to action from the governor with which we responded immediately. There was a an incredible amount of, you know, I mean, anxiety and lack of information, fear from the staff, from the patients, from the physicians themselves. We have lost about eight physicians within our or clinicians, I would say, among our are independent doctors practices.

Dr. Jacqueline Delmont And so we know what it what it meant similarly to our communities, which which are all well aware have had the highest impact, African-American men and Hispanics have had the highest impact in terms of of of illness within COVID and also mortality rates. And a lot of that has to do with with the comorbidities, with residential, you know, segregation, with as I think I was very attentive to the previous panel that talked about the lack of of Internet and access to the digital divide, as they call it. But, you know, we were there, as we said from the beginning, we I think opened what we thought was one of the first testing sites, which was an aqueduct queens, and and then immediately collaborated with with the governor's office to expand it to a six lane massive location, of which I'm the clinical coordinator. And from there, we realized that our communities really could not access those sites because as you mentioned earlier, well, they don't drive. Many of them don't don't have vehicles. They can't pay for an Uber. The Uber didn't want to drive them anyway. So it it we immediately realized that we needed to figure out a way to bring testing to our communities. And so we partnered with the governor's office with Houses of Worship, Catholic and Protestant, predominantly with non for profits such as Core and embedded these testing sites of which we've done both nasal swab and nose swab and NIGG for hundreds of thousands of patients. You know, at that time, I think one of the key elements that we saw was lack of information, even though that the people were being, I guess, overwhelmed by the media with a significant alarm and fear. The reality is there wasn't enough education about what could be done to control the disease, what had to be done when you were ill. We were telling them not to come to the office. We were telling them not to go to the emergency room. And so we immediately implemented telemedicine, which was not as predominant as I heard some of the FQHC's had, because most of our doctors and most of our contacts are capitated. And as you're well aware, that telemedicine was not being reimbursed at the time. And and as was also mentioned, there were issues with our patients not knowing how to access the technology, but they immediately embraced it. And we will serve them either through telephone encounters or through video calls. We partnered with one of our I.T. solutions and we're able to create links that which were much more simpler to trigger when when it was time for the patient's visit and really have done thousands and thousands of telemedicine visits for our patients. We also identified that, like I said, there wasn't enough information about what to do and what the disease meant and what happens once you were ill and what needed to be done within the patient's homes. So we have a call center that was, that's trilingual, so English, Spanish and Mandarin. Because of the composition of our our clinicians and our patients, we take care of almost a million, a million patients among all the twenty five hundred doctors. And that was, I think, an incredible support because it went for seven, you know, seven days a week, almost eighteen hours and in some

instances we were working twenty-four hours. Our doctors understood that, that patients initially didn't want to come to the office. We didn't have enough access to personal protective equipment. And there was truly a very difficult to keep people coming to the office. And eventually some of the doctors remained with their offices open and and some used telemedicine predominantly to care for for their patients. Somos as the sort of liaison for all these independent physicians through their own resources, purchased personal protective equipment that was donated to the physicians so that they could keep, remain with their office is open. We also donated PPE to many of the first responders, to the taxi drivers, to restaurants, to people that were embedded in our community so that they could keep their businesses open. We were talking about, you know, social determinants of health and and how this how COVID has impacted. It wasn't all about treating the ill, but also people that lost their jobs that did not have access to food. So we donated, I think, well above eight hundred thousand meals to people in our communities and as I mentioned earlier, I mean, the amount of testing that we were able to bring to to all our sites, both on at the practice level and through these testing sites, was was unbelievable. We did identify a big issue, which was how to keep up with our quality measures and preventive care, even though in our communities are accustomed to coming and seeing their doctor. They've been, they've had a relationship with us for long periods, so it was difficult to convince them to use telemedicine and obviously for wellness visits for people with such a incidence of chronic illnesses we want to be able to examine them. And it was difficult to even with pediatric population and thirty percent of our of our patients, our pediatric keeping up with their immunizations was was difficult. When we talk about, you know, what have been the which have been the challenges. I think another huge challenge has been data transparency, because not only because of the delay in tests, in test results, but I think in order to manage misinformation to them, I guess from the media, even though we were collaborating with the state, we really didn't have media access to information that we could have used, particularly that are our patients are in in areas that were considered hotspots. Well, we did not understand truly what was the magnitude. I knew because when we opened the site and aquaduct, I mean, almost 70 percent of the people being tested in the first two weeks were positive. But that's because we had access to lab results. Then once they pivoted to being managed by the state and the Department of Health, there wasn't really that immediate access that could have allowed us to be more focused in terms of the education that we could have done for our communities and to answer some of the questions that our patients had. In terms of technology, we I had already mentioned telemedicine, but we also, because of these testing sites that were sort of Seor Kesk with these tents and it was sort of pop up office office setups where there were no printers, where there was you know, we had to transition back to paper. We quickly work with with some of our our vendors to try to get a a software that could allow us to do registration and to schedule people by appointment to take away some of that stress and decrease the amount of contact that our staff had to engage when when you had people showing up as walk ins. So and also that allowed us to notify them about their lab results and communicate about, you know, follow up steps on when they were positive. So I think in terms one of the the other issues that we identified was the issue about behavioral health. And and we already understand that there is a lack of access to behavioral health services, particularly in our community and with providers that speak the language of our patients, which are predominantly Spanish and Mandarin. And with situations such as COVID and the pandemic and the anxiety of not understanding, not having somebody to explain in their own language, plus all the issues of of loss of of life in in in in, you know, family members as well as as their the the issues with loss of jobs are created a lot of depression and anxiety that we found very difficult to to manage for our patients and to find places to refer. We also identified the fact that, you know, with a wide variety of or a wide range of physicians being able to immediately connect with them and

give them guidance on what were the next steps and educate the providers themselves about the changes. I mean, just to keep track and I don't know if you recall about the first two months, the changes in CDC guidelines were constant. And trying to keep a community of twenty five hundred physicians informed about what was the true priorities of what we needed to focus on and how much well, how long was the quarantine this time? If you tested positive, you tested negative. If you were in contact, if you were not in contact. If you word essential worker. If you are not an essential worker, I mean, it was, you know, a myriad of combinations that we had to try to find ways to communicate in and simplify. And I think that having a ways to communicate with our providers, thank God we had systems in place. But it's always a challenge, particularly when many of these providers were facing even financial issues of their own because of their practices being under under the stress of patients not wanting to come to the office and even the staff members not wanting to come to the office to work. Having to furlough their staff, which is something that I don't think many of our independent providers were accustomed to or even understood what that meant. You know, we're not large corporate organizations or hospitals that have huge human resources departments, to, that can support us in these kind and these situations. We were able to very quickly connect with advisors that helped our doctors apply for the PPP program and and help the doctors submit and many of them successfully received funding that allowed them to remain afloat during that that period where they were they were closed. And so, anyway, to to summarize a little bit of what I think are our main suggestions is that the I think that in terms of the reimbursement of telemedicine visits that we feel are going to be very important, particularly that most of our doctors are capitated. And there is a resistance from the payers end to to reimburse for these visits. That's something that I think the customer in general, the especially the younger crowds and the pediatric population and people with with chronic illnesses that are controlled, could allow us to to remain in contact with our patients and even more so in the future for other situations, such as a pandemic is a conversation that needs to be had. And then ultimately, you know, Somos is as a as a hybrid model now with the Heroes Act, we don't feel we don't qualify as a a hospital to receive the type of funding that that hospitals will receive. And even though we were there at the beginning, providing education and support to our ah ah patient population, it's it's going to take a lot of conversation with with the leadership that makes these decisions in order to make them understand that none of the existing models are fit, the type of organization that Somos represents and to really support the the work that we've done and have in funding both for our doctors and for the organization as a whole. So thank you very much.

John Rugge Thank you very much, Dr. Delmont.

John Rugge The usual pause, just in case somebody has an urgent question, wouldn't want to lose track but otherwise, Dr. Mark Foster.

John Rugge Glad to have you here. Thank you.

John Rugge I think you're on mute.

Dr. Mark Foster Yep, yep, got it. Thank you. Thank you for having me. Can I just say ditto and sign off?

Dr. Mark Foster Dr. Delmont's really stated, well, our offices are entirely different, I'll explain a little bit. Our experiences are very much similar. I've been in practice for thirty-two years. I'm MED PD, as John mentioned. We have two two positions, two nurse practitioners here, and I have seventeen support staff. The that includes two and a half

full-time care managers who are embedded in the office as well. So we're in Wappingers Falls, somewhere between here and there. So somewhere between New York City and Albany, just South of Poughkeepsie. So we have our population is anywhere from Medicaid to commercial and to Medicare patients as well too. We have been early on when this first started back, the end of February, beginning of March, I kind of took the gamble and I ordered all the PPE in. So we've been well supplied the entire time. So my colleagues looked to me like I got two heads. Why am I ordering that? And I felt that this was coming and I felt that I'd rather be prepared. And so we were able to to manage it. We even now split our office down entirely so that we had a well and a sick office effort entrance, separate exam room, separate, actually separate airflows. So we've been able to function and operate full time, not missing a day. Patients like Dr. Delmont said, we're afraid to come in. They were being told, don't go to your doctors. So we do that as well telemedicine, which has some use and some limitations. We ended up finding that some patients who are so afraid are coming in and we haven't seen them in almost a year. I called one patient telemedicine to renew his medications for hypertension.

Dr. Mark Foster My first question to him. And so what's your blood pressure doing? His answer was, I don't know. I don't check it. This was a problem.

Dr. Mark Foster So eventually we did renew his medications and have since hadn't come in and reassured him that they were safe to come in the way we have since set up in the office. And his blood pressure was okay, so that's the good news. We've you know, we find that telemedicine still is extremely helpful, especially for some of our behavioral health issues, some of our ADD issues. Some of our answering questions for patients who don't have access we will do video chat on iPhone as well. So but we do find some patients don't have the access for televisits, and that's that could be frustrating for them as well, too. During this time, we we started retooling our case managers to reaching out to a lot of our chronic patients to make sure they're okay, especially our patients at risk. And again, and as Dr. Delmont says, educating them. What they needed to do to stay safe and trying to weed through some of the recommendations from the CDC and the state, which often sometimes were conflicting. And trying to make sense of it for them as well as for ourselves as well. We also hit a point where we had a furlough, half our staff. I mean, we're not a large group, so we don't have the H.R, so that was my call. And I had to call each of their individual staff, about half of them were furloughed. And that was very tough after thirty-two years of doing this, trying to tell them not to come to work. Beginning in May, I made the decision to bring everybody back. And I will say nobody is, nobody said no. Everybody came back and though I realized that there actually someone probably took a financial cut in coming back. Everybody came back, I'm quite proud of that fact. And we've been to continue to be able to support the staff and no one in our office has gotten sick. We've probably diagnosed in the office at least 125, 150 patients with COVID. We unfortunately have lost two. And one very, very sick and ill, who's now recovering as well, too. So I think one of the key lessons or even the frustrations that Dr. Delmont said is sometimes access to getting patients in here, at times getting them educated at times. The other thing would be, you know, having enough support, enough resources out there. Behavioral health has never been good and probably never will be, unfortunately. But I think one of the key lessons we can look at is I think if you look across the country, I mean, who's been in the really true, the frontline. It's been primary care. We go to the hospital every morning, see our patients. You know, we come to the office. We see our patients. We don't close. We're here for the patients all the time. I will say in our area, majority of the specialists did not do that. They either did only telemedicine or they were just closed. So we had a lot of problems in trying to get some more patients who needed procedures done, not elected, but true procedures done in trying to get those done. And I think that put

some patients at risk, unfortunately, thankfully, none of them have been seriously injured or harmed by doing that. But still, it's very frustrating from us when we're sitting here seeing the patients taking the risk, the staff is taking the risk and we can't find other people that are willing to do such. I think this is something that I think has been a problem for years. I think the state, the insurance companies, the government and even the hospitals have undervalued primary care. We do make the diagnosis. We do see the patients. We do take care of them and we do take all their needs into account, yet I don't feel we get the same.

Dr. Mark Foster You know I won't just go and reimbursement because it's dirt, that's always been true, but we don't get the same respect that we should be getting.

Dr. Mark Foster I think primary care should be primary period. So, you know, those are my thoughts.

John Rugge Thank you very much.

John Rugge My support. I am struck by how much commonality indeed there is and what a sense of mission we all share.

John Rugge Moving right along, going to Albany. Joan Hayner, thank you for being here and you are on stage.

Joan Hayner Thank you very much, Dr. Rugge and the Sipek for inviting me to participate this morning. I've really enjoyed listening and learning from the other panelists. And I agree it's remarkable how much we all really do have in common. So let me tell you about Community Care. Community Care Physicians is the largest independent multi specialty medical group practice in the capital region with over 80 practices in Albany, Columbia, Green, Montgomery, Rensselaer, Saratoga, Schenectady and Warren County. For over thirty-five years are physician owned and operated organization that's been dedicated to the delivery of high quality, accessible, cost effective and convenient patient care for all ages using innovative technologies. We have approximately two thousand employees, including more than 420 practitioners, with greater than 60 percent of our services being provided in primary care and the balance being spread over thirty unique specialties. We do also run the residency programs for family medicine and radiology at the Albany Medical Center. With more than three hundred and sixty thousand primary care patients attributed to our practice, CCP cares for approximately one out of every three residents of the greater capital region. Of fact, parenthetically, we discovered in the course of the pandemic was far less known than we had expected. Our payer mix is largely commercial, with approximately twentypercent Medicare, sixteen percent Medicaid and managed Medicaid across our primary care division, although our locations in more or rural or urban settings have significantly higher percentages of patients in government programs than the division as a whole. We suffered similar losses to what Dr. Calman earlier reported as a result of COVID, that was approximately fifteen million dollars. But we were actually somewhat better off in primary care than in our specialty care practices due to the various value based contracts we have using risk adjusted capitation models of payment, which created a financial foundation for the PCP practices. We did have a number of furloughs, no layoffs across the group, particularly in the specialty practices and in our pediatric practices and across our administrative team. And our entire senior leadership team took a twenty percent reduction in compensation as a show of solidarity, solidarity with our team members in the practices who were the ones actually on the front lines providing the care. CCP was an early adopter on the journey towards incorporating a population health

approach to primary care and the development of a value based care delivery system. The value based care infrastructure that we built over the last seventeen years from information technology and clinical data analytics to our expanded care teams, integrating care management, behavioral health, patient education and clinical pharmacy services into primary care have all contributed to our ability to effectively pivot to create the systems and processes needed to effectively identify, isolate and care for COVID patients while continuing to identify and provide care for all the other thousands of non COVID patients to do our best to keep them well. When thinking about the major needs of our patients during the pandemic, so many of those needs seem to hinge on communications and how to keep our patients informed, engaged and well. How are we going to care for the acute respiratory illness that was potentially coronavirus, when we couldn't bring these patients into our practices? How were we to assist patients in getting testing when they weren't sick enough to meet hospitalization. And in our region for a period of time, hospitalized patients were the only patients prioritized for testing. And how were we going to support the region and our patients by keeping them out of the hospitals and well at home? And very importantly, how are we going to manage chronic illness during the shutdown so that we don't find the region contending with yet another health care crisis resulting from the thousands of patients needing but deferring their chronic care? All of these concerns could only be effectively addressed with a robust system of communications for our patients or caregivers, our practitioners and our staff. So communication infrastructure was and continues to be a huge issue for us. Focusing first on our internal communications as a group, we began establishing plans once the first positive case of COVID was reported in Washington State late in January. We formed our CRT, our coded response team, which was a multidisciplinary team of clinicians and administrative leadership across the group to provide guidance to all of our practices regarding protocols for how to manage patients with suspected airborne illness, respiratory illness, infection control procedures, a home management of patients and self isolation at home for our practitioners and staff who had potential exposure as well. Consistency communications, we felt, was really critical. Particularly as we started to experience the firehose of information coming from various sources and agencies, often with conflicting information. So we, our CRT headed had a for the first two months of the pandemic. We had a daily strategy stand up call six mornings a week. Every evening, five days a week, we provided a coded briefing across our entire network of physicians that was primarily clinically based so that we could try to we would spend the day deciphering the information and provide what we felt to be the pertinent relevant and accurate information every night to our practitioners. Twice a week at noontime, I held an administrative town hall and continued to do so with all of our administrative folks across our organization to deal with all the myriad of administrative matters that needed to be addressed because of COVID. And also, very importantly, we used our own behavioral health team to conduct counseling sessions for all of our CCP staff, both active and available to those we had furloughed to help get them through these tough times. We hold one noontime meeting and one evening meeting each week, and we have continued to do that throughout the pandemic. We often have well over 100 folks calling into those sessions, even today. So moving on to communications and care with our patients. Prior to COVID, we were not using telemedicine. However, one week prior to the shut, to the announcement of the shutdown, we had launched a pilot in one of our large primary care offices. It was very clear from that pilot, even a weekend, that that was not going to be an acceptable solution for us, primarily because we were not going to be able to scale it in a rapid manner across our organization. So we quickly did the research and landed on Doxey Dot Me as a solution using their clinical model within that solution that was going to be able to scale quickly. We stood it up in 64 practices for over 360 of our practitioners within ten days of the governor shutdown order. We also made heavy use of what we already had in our fully integrated patient engagement in clinical analytics tools to

identify patients at risk and communicate with all of our patients needing care. In the first two months of the pandemic, we sent over seven hundred and seventy six thousand COVID related messages to our patients. Including what we felt to be the relevant news updates important for our patients to know, organizational changes that would impact their care, testing information and general health care guidance related to the pandemic. We did this with a solution that was multimodal, meaning it could use any device, telephone, text, laptop, etc. It was agnostic to whether it was a P.C. or an Apple product, that didn't matter. Basically, it could be used on anything. And it didn't require any downloading of any applications and really not much of any setup to speak of. Despite this, we faced similar connectivity issues. Even in our suburban settings that we've heard repeatedly reported this morning. Access to broadband Internet is really pretty spotty, even in areas that you wouldn't think so. And many of our patients just simply can't afford it. This is, I believe, a major public health issue to solve. Even patients with internet resources often don't feel comfortable with adopting new technologies. So technology training became a really important aspect of the service we provide, particularly with our seniors. And this isn't, you know, just another barrier to be addressed. We did this with our own teams, but with a group our size that did kind of stretch our resources. So thought of having a statewide telehealth education strategy, I think would be something very helpful to both the patients and to the provider groups. And finally, just related to communications, privacy and security concerns abound. So ensuring that standards are understood and that and they are met. And being able to convey this in a trustful and honest way to our patients so that they felt comfortable engaging. Again, particularly with our seniors, it's really important to gain and maintain their trust. Something as simple as letting them know that their telehealth visit wasn't being recorded was important. That was the question that was asked and continues to be asked often, particularly by our senior patients. Another major issue for us that we felt. We still feel it's imperative to solve was the lack of available testing early on. And although the statewide testing network has obviously ramped up considerably, I'd like to just spend a few minutes talking about what CCP went through. So on March 30th, obviously very early in, CCP stood up our own drive thru testing unit to provide a place for our patients and health care providers to get tested. At that time, facing severe supply shortages and expected spike in the weeks ahead. The regional hospitals, one by one, began limiting their testing as a means of conservation of supplies to their own patients and health care workers. We literally had no place for our patients who were not enough to be hospitalized and our own CCP frontline workers who had potential exposure to get tested. So we stood up our own. Now, interestingly enough, although CCP is recognized by the New York State Department of Health as a fully accredited POL, a physician office laboratory, holds both CLEA and COLA certification and ironically, is listed on the New York State Department of Health website as a COVID testing center. We have had not we have had to move mountains to become recognized and prioritized, is eligible to receive an allocation of testing kit. And we still have received none to today. We even had to get approval out of the Department of Health to our vendors to allow our vendors to even sell us testing kits. So until two weeks ago, our testing center, despite having a state of the art laboratory that performs the necessary, it has the platforms necessary to perform the testing. We have been merely a specimen collecting center. Two weeks ago, we did get approval and received our first allocation of the COVID I.D. now, but we have not been approved yet for the other platforms that would allow us to do batch testing in a much longer and a much easier manner, so that is a huge issue for us. Access to PPE and being prioritized for PPE is a huge issue. And so we were not prioritized as an organization to receive allocation of PPE. So we're often paying multiples of pre COVID pricing for our PPE. Another challenge that I don't hear much discussed, but specifically related to COVID, is the exacerbation of access to care emerging from the aging of our physician community. We focus a lot on our patients at risk, u. Understandably so. But we also need

to consider our physicians who are at risk. We have providers of care who are at risk for COVID either due to age or health concerns or both. We needed to quickly accommodate their needs to keep them safe, but also to keep them available to care for our patients. It's been a particularly difficult time for those practitioners and there will never inevitably be a significant cohort of physicians who make the decision that it's just not worth the last few years they had planned to work until retirement. This is going to cause even more pressure on a system that was facing capacity issues pre COVID. Aside from those concerns, I mentioned the issue of payment parity with telehealth that has already been discussed this morning is really important. We have made those investments already in the infrastructure. The patients are now demanding it now that they've gotten used to it. We've also seen on an unexpected benefits across areas like behavioral health and patient education, where we're seeing higher rates of patient compliance through the use of telehealth. And we, too, are seeing no-show rates plummet through the floor when we use telehealth services. So in a nutshell, to kind of wrap it up, when I think about what would help us respond better for future emergencies, I have to believe that having those who state leadership better understand the critical and critically important role that the community based primary care provider plays in understanding that we need to not only be considered, but we need to have a seat at the table would be a huge start. A coordinated regional effort that includes all of primary care would really benefit everybody in the system. Thank you.

John Rugge Thank you very much. One quick question from the floor, could you just mention again the telehealth App that you listed?

Joan Hayner We have you Doxie dot me, which has multiple levels of participation, there's actually a free level of doxie dot me that is available. It did not meet our needs in terms of integrating with our practice management and patient engagement tools. So we use what they call their clinic platform, and it is still relatively affordable compared to some others. And it's been really quite effective. It's particularly easy for the patients who don't need any special application to use it.

John Rugge Thank you.

John Rugge Good idea, we could put that under the chat line.

John Rugge Moving right along to the Northwell and Dr. McGinn, thank you for joining us and the screen is yours.

Thomas McGinn Thanks for having me.

Thomas McGinn And I appreciate hearing everybody up and listening in since this morning. So I am at Northwell, I'm deputy physician in chief and oversee the physician group. And just to give a little bio there, I am a primary care physician trained in Jacobi's primary care program in the Bronx and then was at Montefiore for six years and then Sinai after that in the primary care center in Harlem. And worked very closely with RQHC's Bereket and Supplement Health in the old days. So just give me a little sense of my background. I'm going to go off script here because I think a lot of people said a lot of things I was going to say. So I think that means is there's a lot of overlap here. And I'm also a data scientist, so I publish a lot and have published a lot about COVID that we published. And I'm not saying this to be boastful, but I'm saying this to kind of clarify what I think the data points are. We published the largest sample of inpatients in the United States, six thousand patients have description in JAMA. Got a lot of interesting press, I

learned how to talk to press, which was fun and. 80 percent of COVID patients never walked into a hospital.

Thomas McGinn Eighty percent.

Thomas McGinn Ninety nine percent of the conversation is about hospitals. Eighty percent of those patients were managed by primary care doctors in the communities and their subspecialists. Those are questions around testing, managing. Then think of the thousands and thousands and thousands of patients who thought they had COVID and called the office. It's it's really overwhelming. We diagnose 50 thousand patients with COVID in our and our labs. About 17,000 of those were inpatients. The others were all managed through our primary care network.

Thomas McGinn So it is really.

Thomas McGinn About time that we really focus on where COVID has been managed, really bad, managed mostly in the ambulatory setting, if you really think about it. And I do think I'm going to kind of end with my I'm going to start with my conclusion. And that is the fall, whether COVID resurges or not, the Fall is going to be a mess, okay? And it's going to be managed on the frontlines of primary care doctors. Every App that every school has, every hospital system, every building has that looks for symptom tracking. Every time somebody gets a sniffle, they're going to call the primary care doc. Pediatricians, internists, family medicine docs and guess what, it's going gonna be the Fall, we're going to have a lot of sniffles, lots of sniffles. It's going to be, I think, of it as sort of a slushy ice storm. The Fall is going to be messy. I don't care whether COVID comes back or not because everybody's going to be stressed that they have COVID every time they sniffle. So that's that's one of the things I just wanted to, that was my end. But let me let me go back a little bit and tell you a little bit about Northwell. I think everybody knows that we're a big hospital system, but we're actually a huge ambulatory network. We have 4,000 physicians. We have 900 ambulatory sites, about 200 of those are primary care. We see all patients on Medicaid, Medicare, commercial. During, y. You know, we have a large ACO, a large number of capitated lives. We are a health first. I know I heard Neil talk about the conflict that we all have with Health First. But we have a huge capitated group, Medicaid patients. We are, we're the largest employer in New York State and those are all at risk lives. Those those are our employees and our families. And that's over 70,000 lives. So, one of the things that I think we're not talking about that I think I'm going to try. Think of what's relatively unique to a large integrated health system that's been doing this over the last few months. And really, we were at the epicenter. We're in Queens and Nassau County, obviously receiving the largest number of COVID patients probably in the country to this date. One of the things that's a little different than I would say some of my colleagues is that we do a lot of what I call a primary care for the complex, specialized patient. So think of all the transplant patients that we care for. A lot of our, you know, end stage heart disease patients who are waiting transplants. Those are managed. We have one of the largest, you know, rheumatologist practices where we're seeing thousands of patients with severe hematologic disorders. And so that goes down the line. And that's something that was a little bit unique and different and trying to manage those patients. So some of the some of the issues that I think about when when I when I was taking notes and asking those questions and not to repeat people, but I do think the issue. And I think we confuse testing with testing and evaluation and I think we ought to be very careful in that distinction. And if one of the lessons that we learned is that it's one thing to do, drive through testing, but it's another thing to test somebody and then see how they are. And those are very different sites. And we quickly realized that we needed to stand up testing

evaluation sites that were typically a person by either a nurse practitioner or a P.A. or, you know, that could do a brief evaluation. And I think we need to be conscious of that triage mechanism as we go forward that, you know, we can get calls and inputs from patients that need testing. But we need to have a branch point where these folks are going to, you know, do we need to know what their I and we need ang sounds like? We need a pulse oximeter, heart rate. We need a quick eye on them and we need to test them. And that's probably about twenty percent of the thousands of patients that need to be tested. When we think about it. One thing that I know a lot of people mentioned, and we did this and I was on the phone from the day this thing started. You know, three or four times a day we had our calls with all our primary care docs, all our subspecialist, all our leadership. The nature of the frequent change of algorithms and treatment protocols, and we need and I think about this going forward. We have some of the greatest medical schools in New York state. We have some of the greatest researchers in New York state. We have some of the great networks and care providers that we just heard. A better coordination and understanding of, you know, what we're all thinking and treating our patients with. I think we'd be somehow coming together and thinking about how we could do that better, because it was a real was a real problem. The other thing, when I think about both what we learned and what we could do better, we we were struggling with a large group of patients that were refusing to go to the hospitals. Our hospitals became COVID hospitals. Forest Hills Hospital, hundred percent covered patients overnight, almost. Long Island Jewish, a 700 bed hospital, Northshore University Hospital, almost all COVID across the board. So we have thousands of patients that were feared, even though they thought they had COVID to go to that hospital. And we learned kind of in the middle of the storm in one of our fabulous pulmonologists, Geeta Lisker, who's in my department, stood up a hospital at home for COVID patients. And we figured out how to do this. We got together some subspecialists. We got we somehow gathered up some pulse oximetry. We got lab work done at home and we called this The Crown Program. And it was basically caring for patients at home, too. And we learned so much we managed hundreds of people at home that would have all been admitted. And only two of those patients out of those three or four hundred patients that had this. And it was all done through telehealth with combination of nurse visits. We managed to keep all of those folks safe at home. And only two ended up getting admitted to the hospital through that program. So I think as we look forward into this, you know, we look at programs like The Crown Program. What what did it take to get that up and running and how do we keep it available and moving forward, particularly for the Fall? The other things that I was thinking about is that that people really weren't mentioning as we as we both what we learned in the in the crisis and then now as I look forward, was the canceling of all the elective procedures and all the screening as a primary care doc, one of my loves and screening that dropped off, that dropped off. Everybody stopped going for their mammograms. Everybody stopped going for the colonoscopies, we are in a process now trying to get those folks back in again. I really think as we look forward to the Fall and maybe a resurgence. What do we do so we don't drop all these preventative services? If there is a resurgence, I mean, I've had at least several of my patients who it was so hard to get them to agree to a colonoscopy. I had three patients scheduled for colonoscopies during the COVID crisis. They canceled those procedures. I can't seem to go back again. It was took me so long to get them to do it. So what could we learn about preventive services during a crisis? And how could we do that better? I do think there's some lessons to be learned there. I think we could do a lot better in that space. The other issue that I think is is extremely important to me is the, is this coordination. I call a coordination and not competition and specifically around testing and PPE. In a sense, we all became competitors, right? To purchase all this material, to do all this testing. And is there a better way as we look at this going forward where we can do an integrated approach across all the different types of provider networks to think about how

we purchase PPE, how we purchase the testing equipment so that we're not battling each other over this. And basically raising the price as we move forward in all of this. And the last thing that I know everyone has talked about is the payment system in virtual care. And I don't want to beat a dead horse. I've been on a couple of calls of large integrated networks and the conversation is scary that's going on across the country from these large integrated networks who all lost, as we did, you know, in the in the in the billions of dollars, large integrated health systems. That the payment structures, if they don't maintain them and fix them, they're going to step backwards. They're going to go back. Because it's all the ancillary billing. It's the EKG. It's the blood work. It's all those things that they are fearful of, losing the billings on those. And that's we don't want that. We do not want to take a step back. But I can hear the national chat already where people are anxious, you know, that they're going to lose all the revenue because it's not going to be captured the way virtual care can capture it. I refuse to take a step back like that. This is why it is so much better for our patients to do to do the care and the way we did it. One of the things that we started during COVID, and I apologize for bouncing around, but I didn't want to be redundant. Many of our primary care docs, when another unique issue for a large integrated health system is. Sixty percent of our primary care docs get pulled to cover COVID units inside the hospital. And so that meant 40 percent of our primary care workforce was caring for 100 percent of the primary care doc patients. And the only way we could do that, particularly since many, many primary care patients had it, was creating a dashboard for each of them for their morning rounds. It was almost it was like an inpatient rounds, except it was in a primary care setting. And it was a nice internal build where we could we could link in and do 10 to 20 telehealth visits within one hour and check in on COVID patients. What was their pulse ox? What was their temperature? What was their heart rate? Now, isn't that a great way to care for a patient? Do that every other day. But we weren't sure we could bill for all of that. And so it's some of these issues around billing for the creative use of telehealth that we all have to sit back and think back because we don't want to take three steps back. All right, I'm going to stop. I know I bounced around a little bit, but I didn't really want to repeat anything that other folks said because I agree with most what everybody has said to this point. For me, the issues are the payment models for virtual care. It's coordinating, not competing, you know, making sure connectivity and broadband, which was mentioned. And I'm a big fan of figuring out how to create clinical standards and do a better job communicating that across various platforms. And I can't wait for the Fall to come because it's going to be a big old mess and so I'll stop right there.

John Rugge Bouncing is really very helpful. Thank you very much, Tom. We in the course of planning, also were able to engage Dr. Talash as the chairman of the board of Somos and thought that you just might, Ramone, have a few comments to make based on not only your own experience, but just observing what we've heard this morning from from all these presenters.

Yeah, I I'm going to be very brief, because I know it's been so long, but I will say it's a wonderful opportunity, but something that we should think about, I'm seeing happening from the beginning, clear that lack of coordination between institutions. Not a hospital where our patients, we let out ourselves, we had to grab whatever was left out there.

You call it from the PPE to real to the test. How would that manage or mismanage in order, in my case, people of color had access to.

We're struggling. We're spending millions of dollars. We had to do a poll. We had to feed my people. Most of the employment happened in our communities. The kids don't have a

computer system. All this seems is to say at the end, I believe institutionally I want to remain, but which I have worked together with more.

Although he did to shore up my parents to understand that he's in this institution. I'm important as hospitals. You go there, are you ready to act? Are they to serve? We are known to word people service. We'll evaluate payment in these first time, what was good for the patient was not bad for the doctors. We want to find out world. And most of the time, so institution can act like that because they don't know where that money would come from to pay salaries because they rely on fee for service. And then something had to be done to look into this. I mean, blind to the stakeholders, the politicians destitution, our. In my case, because when I leave Washington Heights, out of the Bronx, Queen's, corona with most of the dance happening, we implore that we will not. There's no way for us to be isolated. Please allow me to find you some places. Everybody was asking for ventilator's. When we get close to the authorities, more power or relationship, got what they want or what they need. We do not. And we were testing first anybody in the city was 70 percent positive test. The thing is bad to say, but I would love to see coming from this 92 show like this one around the country. Do we prefer embrace to be proud in one day to do what is right for these poor communities? Well, we the suffered the most. For me to say that this country.

Was more prepared to save life on citizen of the United States, with atomic bombs arsenal, than to save life.

The United States citizen with PPE, arsenate, because they didn't have it. Can't get it out of my mind.

Ca'tn get on my mind still.

We love United States of America. 82, shall we preserve it? We don't attack it. Look, you have to be run in different direction. This is business, as always, good to continue that way. Because the people of color, they will suffer the most. And I give you one on the antidote to you guys that I only set that for me was very hard to hear. In the media, on the worst moment of the crisis, what I'm see my own friends dying doctors and their family, and we're going to find their bodies. It wouldn't drugs. We didn't know which one. I heard Anthony Fauci said, now he want to start the players to play a game without fans. Well, they need to be in hotels. And we test every four days and I say, excuse me. I asked him for rooms in jeans, schools, whatever, put a bet with toxemia to people taking taking care there. And you want to put elite people in hotels and to be tested every four days. We don't hyphenation. We don't have testing. But why and I'm asking each one of you why he want to test the people every four days if they're going to be isolated and will be no fans. I don't see any one answer, my friends. Because we, the color people, deliver among and those people. They will be sick and they will be brought the elevators in the hotel, even the full cleaning the room that I'm in the process to serve the elite. That's a lot to say for United States.

That's how we feel in my community.

The way, even as the high levels thing come out. When there was no one test to be found. We got to hear. I'll leave you with a message I hope is an understanding here coming from that. And I hear different like hopital people. I don't mean you that you've got to believe to go on to the king, which belonged to the king. But the community people had to be pay

attention by the community doctors who are serving them. You just say each one of you. We were they weren't taking care, but we had the resources.

And not only that, how difficult is it being for us to recover those resources? Because they know law untie every time that they ask me which hospital, do you belong to. I say, no, I'm belong to the community. I serve that people in the community, that's what I do.

I will do with pride. Even we only take care of Medicaid patients. We don't have private patients. We don't have big insurance patients. But we're proud to serve those one because we decide to open up a small business and displaces.

Thank you for allowing me to.

John Rugge Thank you very much. You're a reminder for all of us. Dr. Gutierrez, had some from thoughts and comments about the nature of health care.

Dr. Gutierrez Let me get myself. Can you hear me? Yeah, I guess so.

John Rugge Yes.

Dr. Gutierrez Let me. I did write my comments. I want to be brief. Let me get back to my chart here.

Dr. Gutierrez Basically, this is what I want to say. And this is probably resonating better with the physicians in the group here. If 90 percent plus of the diagnosis is diagnosis, we may is based on the history. Why are we surprised that telemedicine is working so well? With this pandemic has done is dramatized the role of telemedicine and provide us with an opportunity to witness its value.

Dr. Gutierrez We need to support it, enhance it and prepare ourselves to pay for it. That's all I want to say.

It's just my experience also is, got a charley horse, is some of the little twist, on things would find what we can't do.

We can't draw blood over it until the medicine can't take blood pressures. But have people of people coming to our health centers just for their quick nursing visit and blood draw.

And sometimes it is the pulse ox or whatever.

And just setting up another stream of activity that we never had occasion to think about before is necessary.

And I think that's the kind of innovation we're all experiencing and all doing. Dr. Brown.

Dr. Brown Again, a wonderful panel and I really appreciate the panelists for providing the input they have. I would ask that if the committee can also ask them to provide the same questions as to the questions that I made earlier, I would be grateful. And I don't think even work. Yes. And I think it would be particularly useful to hear from this group accounts to share with us how COVID has impact on your training efforts, your ability to train providers, whether, in fact, we're talking about physicians, mid-level providers or nurses,

how COVID has affected that and what recommendations if you had three suggestions for the New York State Department of Health, what suggestions might you have?

First.

John, can I. Yeah. I wanted to ask Dr. McGinn, a question. I want to clarify something you said about the reimbursement system and the concerns of hospital stepping back, not stepping up, stepping back. And I thought I heard you say because of because of loss of opportunity for multiple ancillary charges. And that seems to kind of be the exact opposite of what we're hearing from a lot of our colleagues here around the importance of some kind of a at least a glide path towards or mechanism to addressing a value based payments, slash managed care, slash capitation, whatever we want to call it. So I wanted to ask you to sort of clarify or help us reality check the issues. And I appreciate that the debt situation for hospitals and being made whole and those things. But going forward, is there a glide path towards a managed care model that hospitals could find acceptable? Or maybe I misunderstood you. Sorry, I just want to clarify that.

Thomas McGinn Yeah. So, yeah, fine. And again, I first of all, I want to clarify, Northwell is not doing this. It was a conversation I had with a group of integrated health system leaders were discussing the fear of loss and a fee for service model. Of some of the ancillary services that are billed and heighten the level of billing, you know, when people come in to be seen, you know, you know how it goes. If you get an EKG or you get an Echo or you get this, you get that. It was a discussion about, you know, on a on a national panel about that fear.

Thomas McGinn And it was just and it was, you know. I like the honesty.

Thomas McGinn You know, that they were talking about this, that if the reimbursement was not figured out to some extent ordinary or it was returned to the way it was, that there would be some losses in that.

Thomas McGinn Does that makes sense?

Yeah, I does, but I don't. I'm not sure that's just my question. I appreciate the discussion that went on. But what I'm hearing, it it seems like there's a there would be a contradiction to moving towards a managed care model if one includes, as you know, bundling or packaging versus continuing to be able to bill for everything that happened. That's what I'm trying to get at here.

Thomas McGinn Right, but I think if that if it's bungled, then you or if you if you're bundling to care and have broader outcome measures, then you don't need to worry about doing a little test here and there to augment the billing codes of the patient coming in. So that you it's all just, you're getting measured on hemoglobin and you're getting measured on broader measures, on visits. And what drives a visit level is typically the ancillaries and other things that are added to that.

Thomas McGinn But if you're being you know, so you're getting out of that mindset, is what I'm saying.

I see, you know, I understand what you're saying, but you think your colleagues, there's a way to to move in that direction as far as they're concerned.

Thomas McGinn I think there is. I mean, I think it's a huge lift, though. I mean, you know, particularly in certain you know, look, look, New York is still a fee for service kingdom, California less so. We have basically this divide between these different states and how they function. And that's true probably even for FQHC's are visit driven, if I understand correctly, I don't want to speak from my FQHC colleagues, but I mean, we just need to get out of that mentality. And I think we lose if we don't break that mentality. We're going to take five steps back. And what we just accomplished because of COVID. I mean, I, I went in and saw one of my colleagues with a dashboard of twenty patients just quit calls. How are you doing? How you doing? How you doing? How are you doing? You know, and there was probably little to no reimbursement for that. But it was probably the most effective way to care for those patients. So I don't know. I'm not trying to say I have the answer for what that model is right now or what it looks like. But we can't be driven towards the old school fee for service model. What's your highest level of code, you can get level three, level four. Whether it's a FQHC or a commercial patient or Medicaid. Because I think we'll eventually all just revert back no matter what beautiful technology we evolved.

Yeah, I, I agree with that. I think in the FQHC World, we are looking at a different payment model, which could be capitated model where you're looking at a total, total cost and not looking at fee for service.

But I think also in the broader in terms of the broader system, we should also be looking at more accountable care types of an arrangements so that you are looking not only at the primary tier, but you're looking at total delivery system services and back and putting that in the mix that you're looking at a total cost of care up and down the system.

Moving along, Ann Monroe, I think you are online.

Ann Monroe Thank you. I know there was a question about training. And I don't want to lose that, but I just want to say that both panels, I've become kind of sad as a result of the panels relating to the issue of mutual respect in the in the larger system, looking at engagement, how low you were on the totem pole for PPE, for other things that were needed to really provide care, as one of you said, in a primary way. And the other mention was that the department doesn't have someone who particularly represents or focuses within the department on primary care. And I don't necessarily need you to all address this or answer this, but in a situation like that where primary care is so essential to what happens to people in our community, and yet it does not have the voice, the representation and to, quote, want to be respect in the circles or at the table. Where do we go from here for that? How does that happen? And as I said, I don't expect to spend a lot of time on that, but I think that's something that we need to really think about. What is our role in advocating an illuminating and highlighting the importance of primary care? So if there are any comments, that's fine, but I don't want to have to skip over the training question that Dr. Brown had.

And I think I think one point, one starting point can be a Zoom meeting of the committees of the council with the kind of participation we've had today.

That's our start in terms of calling attention.

Ann Monroe Good start.

I also think data. I also think data is so important to pick up on what Tom said earlier, there's a tremendous amount of data out there to show how much the primary care

network actually did provide care during this crisis. And I know that based on our population in the capital region, we have upwards of 30 to 50 percent in any of the system centers, hospital centers on a daily basis. But as it related to COVID, we kept our numbers down so low that the hospitals were actually reporting back to us. They were shocked at how few of our networks patients were landing in the hospital. Well, we weren't shocked because every time we'd identified a positive patient, we cared for them at home. We applied all the resources we could to keep them at home and to understand how important that is to the entire ecosystem. It just can't be overstated.

You need to balance. I totally agree. So, I mean, to address Dr. Brown's question about training, so little background of me and stuff that we did once a week in a medical home. Since the very beginning, we thought we are been part of CPC from the very beginning, CPC plus now. So we're a we're a hybrid of of both some capitated plans as well as people of service. But our education in terms of the staff mean because we're small enough that we have daily meetings, we have done meetings with teams based physicians and nurses and secretaries for ten plus years at least. And as such, we were able to have these meetings with such to discuss how we're managing these patients. And our care management team would be reaching out to these patients on a daily basis. And I fully agree, Tom, that 90 percent of our patients, I mean, we've had maybe half a dozen in the hospital and probably diagnosed, like I say, one hundred twenty five hundred fifty patients. And continue to educate them and continue educate our negatives and know that runny nose you had in January of 2019 was not COVID, okay? So you know what this is? This does require a lot of our time. And I'm very impressed with everybody whose comments have come across today, and I'm very appreciative of the camaraderie here. Thank you.

I think I wanted to add.

Go ahead.

Dr. Jacqueline Delmont Well, I think that in the case out of sawmill's and having twenty five hundred independent doctors, I represent about 800 practices, you know, because we've done education to too in terms of value based payment, PCMH, as Dr. Foster mentioned, then what not. We had the infrastructure and the capacity to put policies and procedures together and share it with the doctors and suggest because these are entrepreneurs and independent practitioners that have their own businesses. We can't mandate what we could sift through so much of that information and provide them with a simplified version of this. And these are the best practices that we've been able to compile that are out there and that we suggest for temperature checking, for screening or, you know, bringing back your employees. And how do how does separate staff members, based on their past exposure, an actual, you know, having the disease or not? And, you know, there were many ways and I think part of what Dr. Talash was trying to say is when you have an as a a a body of all physicians that are caring for such a large volume of patients, you need organizations such as Somos to have the recognition and the the financial support in order to do the things that they did for us, such as purchasing PPE and providing all this, the support that we needed at the time where were basically everybody was in hiding and and scared of each other and trying to to, you know, stay away from our accountants, our attorneys. I mean, there was very difficult for for doctors to find the right answers to many of their questions from a business perspective and from a clinical perspective. So, you know, that's I think one of the key elements. And if we are, we provided most of the care and coalgate within are the outpatient community, then it shouldn't be that difficult to understand that reimbursing for visits and looking at data such as, as Dr. McGinn mentioned, you know, let's look at the data to see what was the value

that represented all the work that we did during those years. These last five or six months to understand if it makes sense or not, to maintain many of these.

Dr. Jacqueline Delmont This, you know, these codes so that the doctors can continue providing that, care.

John Ruggie COVID is our learning opportunity.

John Ruggie We have three three questions lined up and not just a few more minutes.

John Ruggie Scott LaRue, are you with us?

Scott LaRue Yes, I am. Yes. Good afternoon. I just wanted to follow up on the gentleman from Somos, you know, and I. I share his passion for what he told us about 70 percent positivity rate and the lack of access to the testing. You know, you see these mobile testing centers that went up in suburban areas using limited resources to test people who were not at high risk for potentially contracting the virus. And it was the same way in the nursing homes. We weren't given access to testing until May. The peak of this crisis was April. And is it the failure on a national level to allocate these resources and set priorities for where the testing went. And even today, people are focused on the number of tests. Who cares how many tests were done? I care how many results were done in 48 hours or less. I almost think it's criminal that they're still taking one hundred dollars a test to give you results that you wait eight days to get and are then meaningless. Yet they're able to do it for Major League Baseball teams. And we have people in the Bronx who can't get tested. So I'm just curious, you know, what people think is this. It was third ability to control this at the state level, or was it really a failure on a national part to allocate these resources based on need.

Do we have any authorities in the room so we can answer?

I will say one comment that I think is some of the other speakers that reflected this about early on in terms of in New York City.

There was a coordinated effort in terms of PPE. I think that was the good news. I think the challenge was that all of that PPE was directed to the hospitals. And so early on, there was a directive from New York City Department of Health and Mental Hygiene that there shouldn't be any testing happening outside of the inpatient hospital setting. So for better or for worse, I think that that was the directive. There was some coordination because of the limited resources that they recognize they have access to. But it was challenging for anybody outside, you know, that the directive was not to provide testing outside of the inpatient setting. So our health centers in your city were not doing so.

We have a lot to. I would just I would just echo on that. That early on I actually received a call from somebody in leadership at the Medical Society of New York State, representing physicians, of course, asking if our group would consider donating our PPE to the hospital. And I was livid. It was a complete lack of understanding of what we were going through and how many patients we were caring for and our needs. As a physician group to have to be recognized to get allocations of PPE and other other testing supplies. So the lack of understanding was not just in the lay people, it was even within our own health care system.

And I wanted to add something the same way that many factories were repurposed to produce PPE. You know, I'm not a, I don't know anything about pharmaceutical companies, but I think there was there was also a business model in this because why couldn't reagents be produced or or, you know, that being triggered so that other labs could perform tests and and not be centralized in one or two labs. So that was always a doubt that we had as primary care providers, because, again, it was mentioned in the beginning that most of the care was provided in the outpatient setting. And precisely, we we needed to keep it that way, too, not because the hospitals were overwhelmed. So I never understood why reagents could not be created and made in other, you know, different types of businesses or factories. When when cars and and other industry car industries are now at work, we're making Petey's and we're making face shields and whatnot. So, you know, there's and again, you know, not having a test for two weeks, but then still being able to bill for that for a result that we're we're not able to use is something that has. You know, it's mind boggling and should be looked at later on from from an auditing perspective because they could have probably done a better job were or or balanced the distribution of testing to two other labs that could absorb along with their own temperature centers.

Good morning and thank you for the presentation. And I know for a fact, and based on what Scott LaRue, they stated that they are fifteen days out in getting a test result. I know that for a fact. I was just wondering, in terms of this almost experience, as I've seen the pop ups of the testing sites in local communities. How was the interface with technology? Did it help in setting up was your access to technology that made the testing and the experience faster, more efficient?

I I guess, well, Alaska, because we ran. I mean, I have open up to date about 60 testing sites from, you know, in the back of a house of worship and a two part car parking lot, too, like I said, all the way to collaborating with the state at Aqueduct. I mean, technology was necessary because it was overwhelming to have to.

And, you know, the paper trail of which we used in the beginning, it became very difficult to be able to respond quickly and so that rapidly implementing a way, even though we had to have people that kind of concierge in on the lines helping some of our grandmas and grandpas and people that didn't have access to to to a mobile or smartphones, helping them register for testing it made the process much more accurate. And we called every single patient, regardless of if the results were negative or positive, because we knew that there were so many questions that people had about the results. I mean, nasal swab versus the IFG. Did I have it? Did I not have it? How come everybody in my house had it and I didn't have it? And, you know, we felt that in order to support our doctors, the only way was to really and, you know, speak and contact everybody based on the results, not just giving sending them a text because, you know, can I go back to work or not? And even the employers were extremely confused about what to do with results. So, yes, technology was the only way for us to make sure that we were tracking that we were calling everybody and following up with everybody and that there were no mistakes in terms of identity. And so we move very quickly to try to implement all these resources as soon as possible.

John, I think Glenn Martin had has been waiting for some time. Sorry. I just I that I would watch as well.

Dr. Martin, you're doing our wrap up, final question.

You're on mute, Glenn. There you go.

So, first of fact, recognizing me, secondly, thank you, everyone, for your presentation.

They have been fascinating, though I must admit I feel a little bit frustrated at the moment because this is one of those classic collection of anecdotes rather than collection event of evidence. So I am frustrated in not knowing what actually happened. And in any of the circumstances that we're discussing, I can certainly understand that the medical society poaching for equipment PPE from a large physician's practice certainly sounds tone deaf.

On the other hand, I suspect that there were hospitals that had no PPE and were flooded with patients who desperately needed it. And the asking around is somebody have extra or can they they virt? It wouldn't strike me as an absurd thing for them to do. On the other hand, I have no idea what the actual supply situation was in New York State. We asked about it before the epidemic pandemic hit and we're reassured that we are in good shape.

And the reality on the ground was that it's not true. Certainly not in terms of distribution. I know that Dr. McGinn mentioned the fact that we basically stopped those screenings, which is true.

However, the impact of that is still not clear to me, because if you pick up your mammogram, your colon, whatever it is, you need it to be screened for it with the next number of months. The actual impact on public health is not excruciatingly obvious to me, at least.

So I was going to have something specifically about the the the potential siloing effect of mental health. But I won't at this point, as much as a general system plea is that I hope that somewhere in the agenda sorry, public health and our planning committee agenda, we will actually get the larger fact base after action analysis that I presume are being done somewhere within the state and use that in addition to the excellent testimony that we're hearing today. So that did my specific question. I'll wait for some other time.

This an excellent valedictory. We may need, as this special committee of the council, chaired by Glenn Martin, to go after all the evidence to put it all together. Be careful what you ask for, Glenn.

Careful what you do.

But beyond that, once again, just want to thank all the participants, all the commentary.

This is the one thing we can do as a council. I think best to to try to showcase and highlight the activities going on in the primary care world.

And would must not be lost or subsumed.

Our public and our patients and our communities need us. We'll be here for them. With that, we will pause and reopen with a meeting of the public health committee and health planning to address public health issues.

Once again.

At one o'clock, I think we can do it right on time. Thanks.

Jo Boufford Yep. All right. Well, why don't we, I think all our panel is all here welcome, Executive McCoy. And we'll have, I'll be introducing each of you. I want to again, let me just start formally, Jo Boufford, I'm the chair of the Public Health Committee of the State Public Health and Health Planning Council, and with my colleague John Rugge, who is on the screen, who is chair of the Health Planning Committee, and with considerable help from Anne Monroe who we put together I think a great morning this morning with two panels on primary care, really looking at experiences under COVID, lessons learned and how they might apply to preparing for any resurgence and or future such emergencies, as well as inform a health care reform. And the panel this afternoon from 1:00 to 2:30 is to focus on a very similar, if you will, examination of the public health sector. So we're delighted to have a great panel. And let me just introduce them first and then I'm going to talk to you and tell you a little bit about what we've, maybe I'll tell you about what we've asked them to do. What we've done is we've asked each year of it's a little modification on the morning's work with our colleagues in primary care. Asking them to really look at what are the lessons that they learned during the COVID epidemic and how could these help you be most effective in the in any future resurgence or future emergency. And then what priorities would you identify to strengthen the public health sector in the future, you know, health sector reform, health system reform, both from emergency response and a non emergency response point of view. And then my colleagues have identified a couple of extra questions we're going to ask. So the panel, Sarah Ravenhall is the executive director of the New York State Association of City County Health Officer. Sarah, just raise your hand for those that haven't met you, if you don't mind. And I've asked Sarah to give a little bit of an overview of what local health departments do. Thinking that we may or may not be that familiar with them, in addition to talking about some of the trends that were noted during the epidemic across the state. Daniel McCoy, who is the Albany County executive. Dan, you raise your hand. Your name is there. He is going to speak second because he's got a time commitment. He has to leave us ten minutes before 2:00.

Jo Boufford And we've asked him, actually, Kevin Watkins is responsible for his being involved because Kevin was telling us, as we talked to him, how important the county executives were really around the state in mobilizing and managing, leading, if you will, emergency response at the county level and also their relationship to the local health departments. And so we've asked the county executive to talk, talk about that. The third speaker will be Sherlita, or will be Kevin Watkins, who is a member of our council and the the public health director for Cattaraugus County Department of Health and Sherlita Amler. Sherlita, maybe raise your hand for people who don't know you. Sherlita is the commissioner of health of Westchester County. We want, again, getting good geographic distribution and experience differences. So I think without further ado, why don't we get under way and I'll ask Sara Ravenhall to start us off. Sarah.

Sarah Ravenhall Thank you so much, Dr. Boufford. My name is Sarah Ravenhall. I'm the executive director at the New York State Association of County Health Officials, NYSACHO, representing all fifty eight local health departments in our great state. Thank you to the Public Health and Health Planning Council members for the opportunity to speak with you today about the critical role local health departments and NYSACHO play in improving the health and well-being of communities and what we've achieved collaboratively to mitigate COVID-19. There's a common saying in the public health landscape, and it's if you've seen one local health department, you've seen one local health department. Meaning that each local health department across the state is unique. It serves different communities. It provides different services. It's governed differently. It has access to unique resources and variability in staffing and its workforce. But broadly, these health departments are committed to improving the health of the population that they

serve. Because of this reason, flexibility is absolutely critical when considering making investments in state public health infrastructure, particularly local health departments. So local health departments are agencies of county government that work closely with the State Department of Health. In York State, these departments operate under the statutory authority of Articles three and six of public health law and the general supervision of the state commissioner of health. Local health departments provide core public health services under public health law. These core public health services include emergency preparedness and response, which is critical to responding to the COVID-19 pandemic, family health, communicable disease, chronic disease, community health assessments. And for the thirty six full service local health departments, they provide environmental health services. Local health departments oversee a broad spectrum of services within their domains while ensuring equity, cultural and linguistic diversity, inclusively of various populations and then protections to those who are most vulnerable within the community that they serve. Emergency preparedness, planning and response is not new to local health departments. Over time, local health departments have confronted and mitigated a broad spectrum of communicable diseases; Zika, H1N1, Ebola, the list goes on. Professionals employed by local health departments are really on the frontlines of the COVID-19 pandemic. They're working to protect their communities from exposure to this relentless virus. Some of the activities they're overseeing include activating and mobilizing emergency preparedness plans during local emergency or outbreak response, serving as communicable disease experts by conducting epidemiological investigations, contact tracing, monitoring suspected cases, enforcing isolation and quarantine protocols, and setting up mass clinics. Assisting and connecting vulnerable or under-resourced individuals to life sustaining resources like housing, nutritious meals, utilities, health or mental health services. Supporting community partners and working hand-in-hand with state agencies. They maintain strong community partnerships with hospitals, colleges, schools, businesses, community based organizations and volunteer groups. They also uphold state and local laws. New York's local health departments are the only boots on the ground entities legally responsible for the control of communicable disease. They also, and very importantly, keep community members informed by providing up to date information about the outbreak and local community impact. So as for the Membership Association for New York's Local Health Departments, NYSACHO was adapted swiftly to the pandemic by refocusing our programmatic priorities to support COVID-19 mitigation and response efforts. NYSACHO holds really unique insight into the state level voice of the local level, voice and experience of local health departments during the pandemic. And our professional role, we maintain constant communication with local health departments and state partners to ensure current and accurate information is being shared. We identify common barriers and needs. We connect our members with the resources resources that they need to better assist communities statewide. And we advocate for policies and funding that will allow local health departments to strengthen protection measures for community members across the state from this pandemic. We have learned firsthand that a robust public health infrastructure is critical to our collective success in containing communicable disease outbreak. Our public health workforce outside of New York City has decreased by one third between 2011 and 2018. We're already seeing how counties furlough lay off and offer early retirement incentives to staff members. With a large percentage of local health department staffing eligible for early retirement. We're at serious risk of losing decades of collective public health expertise that's truly needed to address future public health emergencies. Stagnant state aid, tax caps, funding eligibility restrictions and all other administrative barriers all undermined the local public health infrastructure, which we all collectively rely on in public health emergencies. Emergency funding must be provided to localities upfront and spending restrictions should be eliminated to ensure counties can use the funding in ways that best meet community need.

Local health departments serve as operational extensions into New York's communities. To ensure that localities are messaging in alignment with the state, it's imperative that communication occurs between states and localities before its message to the public. When the public calls our local health departments with questions about new executive orders or mandates. We ask public health officials want to be able to answer those questions and offer support in order to build community trust and reassure the public. So we've also seen that there have been gaps in availability of testing for COVID-19 in communities across the state. Community members frequently call their local health department for information on where free COVID-9 testing is available and we continue to see barriers to accessing testing. Whether it's, you know, the time it takes to travel to a testing site, lack of access to transportation, high insurance, co-pays or deductibles. These are real issues that are going to exacerbate as we approach school reopening. From a regulatory perspective, NYSACHO recommends the following; in the current New York Code's rules and regulations, Section ten two point six language authorizes the state health commissioner authority to step in and take over as the lead on a public health investigation locally. We recommend that this language be revised to allow the state to take the lead when a local health department indicates that it lacks the necessary capacity or jurisdiction to perform the investigation. As community leaders, county health officials should have the authority to request and necessitate that the state take the lead as needed. And we think that this is going to be really, really critical due to the fiscal strain and economic fallout associated with this pandemic. So feel that it's incredibly important. The State Department of Health has been a very reliable and trusted partner over time. But we do feel strongly that these regulations should go both ways to strengthen the state and local response efforts and spread accountability across resources that are available. Local health departments are run by county health officials. These public health experts are trusted within the community and are the lead for to all topics related to health. So if a community member has a question about vaccine administration, blood lead levels, water contamination. Successful communication is dependent on established trust in communication from a city or county health official. This is what communities rely on and turn to in times of need from their local health department. So moving forward, our recommendation is for states and localities to work together to engage in reflection and make improvements in planning around emergency response that will protect our communities from the next wave of COVID-19. We really want to be certain that these improvements represent the voice, expertise and suggestions from the local health departments who've been working day and night to mitigate community spread of COVID-19 and protect the health and safety of communities. Thank you so much.

Jo Boufford Thanks very much, Sarah. I should have, I didn't mention the format. We will each speaker has been asked to speak, you know, ten to twelve minutes or so and then we will have Q&A at the end. I should have mentioned before that we had had the commissioner of health of New York City was going to be joining us, but for reasons that are sure known to everyone, there will not be that individual. So we are not admitting New York City, we just weren't able to get someone. So for future time, we will hear from New York City directly, so Sherlita's the closest. So she'll tell us a little bit about that. So, county executive McCoy, welcome and the floor is yours.

Daniel P. McCoy Thank you, doctor. And Sarah, thank you for liberating on department help. I think one of the biggest issues we had at the beginning was the state had no idea the county run health departments. The federal government has no idea. I'm in a unique situation because President County Executive's of America and President of NYSAC at the same time. Unfortunately, during this virus, it's I have on a roll on a natural level as well as statewide and the feds had no idea, they just thought the states handled the health

department. The governor in the state had no earthly idea how involved we are. I don't want him he didn't or she or they didn't. But it was problematic as it started to take off. And one of the couple of things that I had advantage versus other executives or elected officials. I spent twenty-one years in the fire service, retired out of fire service. I have thirty one years in the military National Guard, multiple tours. I was in Iraq. So it kind of gave me a different outlook when this happened. And we start following his back in January. And as we were following it and he was stepping up throughout the country and and meetings took off and we had our first case, March 12th. And by the 15th, I took my office and I put us in three different locations. I moved my deputy away from us. I moved staff. I broke them up. I broke my commissioners up versus deputy commissioner, set them up, set some home to work home sent some two different locations. Our EOC was established. And a lot of my workers and beginning had no idea what I was doing. They thought I was panicking. They didn't understand it because we've never dealt with something like this. But I knew dealing with other things in the war and the fire service, you had to be prepared. And I said we lose, if I go down, then it falls to the next person. Governments will have to run. Services still have to be provided and people need to understand what's going on, you know, to stop the panic. The first, the second thing I did was set up a mental health hotline for our mental health department is like you don't realize that mental health. People's mindset are going to change the unfortunately, the reality of the world changing. People are having a hard time grasping it. And one of things being in the combat zone, you see that with soldiers. You know, you don't know what how you're going to act to get your first firefight or something happens and it changes you. So I knew that world changing in this situation we're going in. I set that up and a few other things. And as we went forward, you know, it's lessons learned. And when the governor took away the power of the county executive in the counties to make any decisions was a little bit more problematic. And it was good on the fact that you want decisions made at one level, because if I don't agree with my counterpart across the river or the one on the other side of me, and we do things differently, it doesn't help if we're not all the same sheet music. It was a hard pill to swallow for a lot of people in the beginning because they weren't listening to us in the beginning and in that kind of change as we went forward. But again, you know, there's lessons learned for everyone on this and as we continue to go down this path. One of the things I know right away was our nursing home. And I shut it down. I shut our nursing home down to visitors right away. I shut it down, trying to shut it down to visit. A lot of nursing homes had a problem. Another area people didn't pay attention to was a lot of these nursing homes had visiting nurses. They shared nurses; RN's, CNA's, LPN's. They'll work at our nursing home one day. They work at Schenectady the next day. They might work with Columbia County, the third day. So it becomes that natural conduit of spreading it around a little bit quicker. And the other conscious decision I took on in the beginning was there was no clear cut decision from the State Health Department of how we were going to add if someone died in a nursing home. The only way we had to start counting it is the after seven people passed away in the nursing home. I said, screw that, I'm going to count one and I'm going to let everyone know where we're at. How do you change the seriousness of the situation for the workers to grasp what's going on? If, A, I don't tell him the person died from COVID and B, if I'm shipping them out. And that's what you saw in a lot of nursing homes across the state in New York. They shipped them out. So if they died at a local hospital, it didn't count against that nursing home. So a lot of people that died within eight hours of being at a hospital got put under the category of that hospital, not the nursing home they came from. Again, you can't get a real read on the situation of the problem or the magnitude. Again, is coordinating all the services in a partnership when I don't want speak for other counties, but I have roughly three hundred and twenty thousand people, nineteen municipalities. So I have eighteen mayors and supervisors of different capacities that we all have to get on listening to music and start

that communication. Which we did, and it was rough. You know, there's a lot of lessons learned in this. I had a health department that has a medical corps reserve that does a phenomenal job but never had to deal with something. This was new for everyone. So I decided early on to not to point the finger. I said, look at the scholars. You're going to come together like this back here. They're going to decide what we did right, what we did wrong, how we can fix it going into the future. And one of the things with the health department, they never had set up EOC. They never had you know, they practice it once in a blue moon, not to this magnitude. And not seven days a week, twenty-four hours a day. So that was all lessons learned in the beginning in modernizing the way we do things in the workforce. You know, when we were reducing workers to go home the next day at home order and say fifty percent of our workforce home. We were, we didn't have the capacity to send people home with computers, who didn't have computers. We did have ways for them to come in. And we didn't have ways for them to do work, you know. So it was a new way of looking at how we function as a government in going forward. And then work with school districts, because instead of setting up internet and all that stuff from the beginning, the schools, for whatever reason and I leave this to the people on this panel, I still I never really got into. Why the schools are responsible for feeding kids? So they're priority instead of education off the get go was you have to get the kids fed. Which is important, but that could of fell to the local governments that could have fell to something else. So the school districts, instead of setting up Zoom or setting up to continue on school, was running in circles, set up how to feed these kids and that was problematic. And then we had rural communities with no internet. So we set that up. So I worked with our little town school and we paid for it. So there's no time to sit there and try to find the money or wait for the money. So we paid for a lot of the internet services for families that could afford to put Internet or iPad to get kids learn because we wanted schools going on. So as we move forward and continue to go on, one of the issues we had was with mobile testing and underlining communities in Albany county that have issues, predominantly the African-American community was affected more on a national level in parts of the state in their county. But we weren't sure that. So a lot of people don't have transportation. It's great to have all these testing sites. What if you don't have a car and you can't Lift or Uber there or take a bus there? How are you going to get tested? So we set up mobile testing right away and all the candidates it. I want to thank Dr. Wailin and her team of the health department, my people in my office. We did it together with Whitney Young and we got it up and running and we brought it to the neighborhoods and brought it to the street corners so people can get tested. And we can track it better to see how this was affecting this community that was being hit hardest on the natural. And early on, I noticed I just started watching the twenty to twenty nine year olds that were being that were getting tested, that had no signs or symptoms, but were being infected more and spreading it to everyone else. So we start paying attention to things like that. And again, reach out to my other executives across the state here working with Mayor De Blasio on talking to Mark Hearts out in Eric county, Steve Newhouse, Orange county, being on the phone all night long because we were helping each other through this. And the other big issue was the PPE. No one was ready. And no one had the N95 mask. There was a lot of people and it wasn't getting out fast enough. People were asking for help. And I think it was an overload on the state. It was an overload on the counties and towns and cities, villages. So we ended up sharing a lot of equipment and services between the counties, more so than the media ever picked up or anyone else, because we're just helping each other out. And I was watching it when it started in New Rochelle. I knew that, you know, the wave it was spreading to Putnam County, Dutchess Orange eventually was going to hit us. So I had some time and I had lessons learned to, you know, George Latimer to see how they handled it, what they did wrong, what they did right. And I made the conscious decision that beginning not to point fingers because will be enough time for that down the road.

People need leadership that duty. The other thing was when the set up that controlled for all of us, that how we're going to open up working with six other counties in the capital district became problematic because our friends up North weren't being affected like we were. And we're holding them back to being opened up, fingers point. But the control room was forced to deal with all that and we were supposed to have a say. And we learned shortly, we really didn't ever say. We just asks questions and we wait for lives. We really had no say how we're going to open up going forward. The other issue with the State Department Health, there was a lot of misinformation. They would put out stuff and certain people we were getting information from or word was coming out. They weren't on the same sheet of music. So it was confusing for a while of saying, wait, you need to organize the same boat. We need to have constant communication coming out together as one or this isn't going to work. And it still happened like we we reported one day, I want to say a couple of months ago. We found out we lost twenty people in that passed away in my county, that we had no idea. Never went through our health department, never was notified. And then within that next twenty-four hours, I found out there's another thirty two people. So one day I had a report over fifty people that passed away that we had no idea. And I took it on the chin and I put it out there. And it was because nursing homes under state law don't have to notify the local health department that they can just notify Department of Health and Department Health wasn't telling us. It was that communication piece that we had to keep working on. And then the numbers, when we want to reopen up the numbers that they're using for hospitalizations, they were well, way off. And we had to argue the fact that they were wrong and we came up why they were wrong. And then I worked with Mark Bonaparte's out in Erie county, came up. So we wasted a lot of time just saying, look, here's our we're not that dumb. I know we're only on the county level, but, you know, we do have talented doctors and professionals that volunteer or work for us that know how to get through this crisis. And we kind of like work together. So lessons learned in going forward is definitely partnerships, better communications and I hate to say it. I'll give it credit system. It was I kind of chuckle when they first said it. They go CCR. I go, what do you mean CCR? I can't take any more abbreviations. They go communication coverage, results. And that's the lesson learned for me, is better communications from state officials that if they want to run it, then that's fine. But they have to understand what we do on the county level to affect the way we make things work to go forward. That was like the biggest problem and it stil is. We still have issues with data. We still have issues with some orders, you know, and then the enforcement keeps going forward now, you know, going after your restaurants and bars, fining people. When people are just trying to reimagine how their work area is going to be and everything else. And in the health department being called upon the school districts because they want to do the math and trace in which we have done great. Our people at our health department matched up to anyone in the state of New York, especially the state. They should actually come to our building and learn how to do it correctly, because we established it quick. And I will say this, my health commissioner and her team did. So I don't want to take credit for that or act like it was me.

Daniel P. McCoy It was my health department doing what they do best and doing their job.

Daniel P. McCoy But as you continue to move forward, if we don't work together and take the lessons from this in and change it. If we hit a second wave in October, it's going to be problematic. And the other issues that we're having that we're trying to address is the high seas, right? Domestic violence abuse that went down because people aren't reporting it. Kids that are neglected that the teachers, the mandatory reporters that now are reporting these kids being neglected and all these numbers dropped, you know, and they're not

dropping because it's good. We did a great job, there dropping because no one's reporting. And trying to get kids back in school. I would say, you know, that that's the biggest question. And, you know, the one thing I will say this, you know, to look around this nation in the world, how they handled it, you know, lessons learned in communications. And talking to other governors I talked to around this country at a national level because they thought everything else and fighting bills that had the federal government understand because we know when the Cares Act came out, it was for counties with over five hundred thousand people. We got left out. And that's the problem that happens. And then you see a lot of towns, cities and villages that are doing great things that this is affecting them. And right now, we're looking at two crises as we go forward. Health and economic crisis, because we are going to crash in the next couple of months. You'll see people, more businesses closed. You're going to see more issues going on and that's a whole other area. But it does affect the health if we get another wave of this. Can we shut down? And I've always said this, the safety and health of the residents are foremost with me. The economy and the money second. As I am matching a dollar or a million dollars to anyone's life. So we have to do what's right in finding the money to get things done. And that's been the most challenging thing to we know we're off about thirty million in our budget so far, but we're probably going to be up to about forty or fifty very shortly. Just had a meeting with the governor's office about how much money they're going to put out. They don't get bailed out the federal government. And resupplying my nursing home staff that's burnt out. And my health department that needs some breathing room that had been on the forefront with everyone else. As we continue to go forward, so I won't say it's anyone on this panel. The best thing to do is share the good, the bad, the ugly with everyone trying to learn as quick as we can to fix this. So if we hit a second wave, that we can get through this together. And, you know, I know my constituents scream at me. I had a guy threaten me when I was at a red light and I go, I don't even go out anymore. As people mandate, they feel like we're locking them down. And I know the governor is doing to people to reopen this way, but they're trying to stop the spread. Because I told everyone, you may be down with this virus, but the virus isn't done with you. And I can assure everyone on here, when I'm seeing travel basketball go on and kids out playing basketball and acting like nothing's going on. It's it's it's tough. I don't know what it takes to really wake people up to feel it. But unfortunately, we're a society if it doesn't affect someone you love or someone passed away from it, that you know you'll like yeah, I'm good. But so as we've been going forward in working with Steve Correo from NYSAC and Mike Griffin and they feel really is that communication. What we doing is saying that to get it right, we need to look at how other people handled it to move forward with the travel ban. I know that's tough for a lot of people, but people are going. Everyone that comes back is infected usually. And it's kind of like, I'll leave this to the doctors. I feel like I play a doctor at my press conferences every day. But it's morphing. It's changing.

Daniel P. McCoy It's affecting differently Georgia, Florida differently than New York. And if you bring that back, this is never going to go away until we get a vaccine. And one of the things we said constantly with the governor's office and the control room meetings that I have every day at fourteen hundred. Is that, we need to have better communication, which we are, I had the pleasure of working with General Murphy at of our control room every day and Joe Rovito. And they do try to get back to us, but it's frustrating when you're trying to just get straight answers. And again, all be working together, because at the end of the day, we work. You know, we all represent the same people. And it's about the health and safety of everyone. So the lesson biggest lesson I learned from this is just not be afraid that you don't know the right answers to find out who's doing it right. And don't be afraid to change and tell people that, hey, look at you know, it's like with the nursing home, I've tried my best. The fact that I lost fifteen people there bother me, every one of them. And one

hundred twenty nine people I've lost in this county bothers me every day. Because we are trying to do our job and we're trying to protect the people. And again, people got to realize we're in this together. And the time for finger pointing down the road. We just need results and we need leadership.

Daniel P. McCoy I can keep going, I'm a politician. I could keep, I don't want to bore you. So I'll take questions or.

Jo Boufford No, that's great. I know you have to leave a little early. I'm wondering, perhaps, we could ask open to the counsel for questions of you and Sarah Ravenhall, just in general, the overview, sort of general overview, that kind of things that you've given us on the issues that you've raised. I think Anne Monroe had a question for you, Mr. McCoy.

Anne Monroe Yes, thank you. Did, I know that your health department did work on dealing with this crisis. Were you able to bring other county departments into the mix and how were they in responding to this crisis kind of outside of their usual work?

Daniel P. McCoy Excellent question, and I'm glad you brought that up, because our DPW, our highway department pace stepped up. They were doing parades. They helped with, you know, obviously, when we got the order from the governor with that, we had a visit every house that was under quarantine and check out.

Daniel P. McCoy They stepped up and the men and women of our DPW department were phenomenal. Probation right? Because the court system really shut down for sixteen weeks and went home and that's a whole other chapter of the OCA. I'm not going to get into that. But our probation officers, they stepped up. You know, they were going out and doing checks and did different things. We took people that were from other departments, from DSS, from children, youth and family. Every department went down there and was answering phones, was doing tracing whatever gap we need to fill in there. So really, I learned a lot in that of how I have a great workforce. And then you get the workers that don't want to work in the internet, too. But I have to tell you, most people rolled up their sleeves and they came, they came knocking and it worked.

Anne Monroe Thank you.

Sarah Ravenhall I speak to that as well.

Sarah Ravenhall NYSACHO is conducting an in progress review with local health departments to find out what their, you know, best solutions were for the COVID-19 pandemics and then their pandemic response and then where where there were gaps in learning or where there are areas of improvement. And one of the strongest and most effective things that they recognized was successful in their COVID response was intergovernmental collaboration, working with other agencies. So it's really wonderful to hear how leaders within the county and as the county executive talked about, you know, recognize that public health needed support from those other departments and made those linkages. That was really a successful outcome.

Jo Boufford Great. Glenn Martin has a question.

Glenn Martin Thank you. I guess one of the things I'm still confused by is Pandemic's has got to be one of the most predicted disasters of this sort.

Glenn Martin The public health has been aware of for decades, yet it seems to me that we were sort of behind the ball from the beginning. Even when we had days, weeks of notice that it was coming. So from your perspective is it that we don't plan adequately. We don't meet enough that we plan, but then, of course, like everyone, we plan for something and we put it in a book and we don't read it until the day we need it. Then we go, oh, crap, we forgot to finish that chapter. Or what do you think with the story?

Glenn Martin When you look back and I guess I poses this to the county executive as well as Ms. Ravenhall.

Daniel P. McCoy I can tell you is what a excellent point that you're making and I can go in every different direction.

Daniel P. McCoy We look at our health department in medical reserves, Core, the volunteers, they train for everything, right? But you're trained for everything and not know how you adapt to it. And and again, all the finger pointing at the national level, at the state level. Why weren't people paying attention? And my opinion was that we all saw it going on around the world. No one was buying into it. And I start watching Italy and I'm like, man, we're about ten days behind Italy. Again, not the expert. Just from watching the news in other segments and how governments were handling it. So we there were certain areas we were ready for it. There wasn't certain other areas. And I think that the T crossed lesson learned. The sheriff does a great job setting up EOC falls under me. Him and I are always on the same sheet of music because of the snowstorms. I would things. I think for our own speaking, just for my health department, it was a shocker set up in EOC and to have to have personnel there 24/7. Again, when you train on a tabletop or three day exercise and then like you said, you go away or, you know, it comes down to other issues that you're having, two percent budget cuts, money being grants being cut out from the state federal level. Even before this happened and sitting there trying to for our ties to health, you know, we we're doing air monitoring in south end four tractor trailers and bomb trains, everything else. So we had a lot of other things going on. And I'm not making excuses. It was a lesson learned to say, hey, look, you can't just look at it. We have to look at the overall picture. And in here, our emergency manager, we lose to the state of New York. And unbeknownst to us, we open up the door when we're all open for 95 masks and we had forty thousand of them. And ordered all this PPE that she didn't tell anyone that hid it for occasions like this and called us and said, hey, you know, I did this to prepare for last time. And just slowly was buying stuff without telling anyone and stuffing it in a closet. And literally be put in bags. It's funny now to look at. At the time, I'm like, why? But it was good. And, you know, the lesson learned is really planning an awesome points. And I want to really say that because I've learned so much through this personally. And I think for the health department going forward, you know, how big is your budget? Because that's what's going to happen, right?. And everything's going to be cut next year. Every program by twenty percent, not more if the state doesn't get bailed out. And it's a ripple effect that comes down. But now, more than ever, I need my health department and I need what they do in a community. And the other good thing I take away from this, because you've got to take the positives and negatives. The positive thing is, I can assure you most the resonance of all the county had no idea what the health department does. You know, we've got a clinic, we got a dental clinic. So for people to really realize now that Dr. Weil, it's just not a figurehead..And all this stuff, I think is all I take the positive from. I won't say awesome that we were going through this, but nice the fact now that people are attuned to what they do.

Sarah Ravenhall Thank you and I'm glad you're.

Jo Boufford Go ahead.

Jo Boufford No, go ahead, Sarah.

Jo Boufford He was giving me a great segway into hearing from our other two speakers, so I just wanted to pick up on it, but please speak.

Sarah Ravenhall Okay, I'll I'll be quick. I'm glad you asked this question. I actually believe that county health officials and the local health departments are were very well prepared and saw this coming. They knew it was coming. They are very used to responding to communicable disease outbreak and working collaboratively with the State Department of Health on pandemic response. They do drills their experts in contact tracing investigations, working with the community.

Sarah Ravenhall The magnitude of this pandemic was something that we didn't expect. And this goes back to what I was talking about earlier, about, you know, public health infrastructure and the retiring. To years of expertise that we need to really really protect and make sure that we have a next round of professionals ready to step into local health departments and take over these positions that are going to be leaving the local health departments. Public health response takes public health workers. And we really really want to make sure that we have people, a robust public health infrastructure to address any public health crisis that comes up not only pandemics, water contamination, you know, weather, weather issues and disasters, hurricanes, anything that comes up. So I'm glad you asked the question, I think it's very important.

Jo Boufford Let me. Are there any other any other burning questions for the county executive?

Oh, sorry. It was really more for Sarah.

Jo Boufford Or for Sarah. It's fine.

I'm wondering whether there are mutual aid agreements which we will help both local or whether you saw going to the State Health Department is the only way to do that.

Sarah Ravenhall Yeah. There are mutual aid agreements between some of the counties. And, you know, I know they've been in existence for many years and we've been starting to explore that with our partners at the State Department of Health more often. And this particularly came out of the measles outbreak that happened last year. So I think that is a successful model, but we need to continue to work with the State Department of Health to make sure that, you know, that the federal to state to local funding is coming through and that we're working collaboratively to address this. And we also want to make sure that guidance is consistent across the state, not fragmented or piecemeal. We want to make sure we're doing as much as possible in the same fashion in different counties across the state.

Jo Boufford Let me just recognize Laura Santelli. Laura's joined us. She's obviously the front line between local health departments and the department. Would you like to say anything now or are you sort of welcome to chime in when you wish to you go ahead.

Jo Boufford We can't hear you, sorry. We can't hear you.

Jo Boufford Maybe we'll come back now, then. Oh, there you are.

Jo Boufford Okay, perfect.

Laura Sorry, too much technology here, so. Thank you all very much.

Laura It's good to see you all in this capacity and glad to be listening in. And I do, you know, definitely echo the same sentiments about you can you can prepare as much as you can, but until you really get into the mix of it, you know, you don't know what you have to you have it on on your plate. And I do believe, you know, you've done an amazing job with unprecedented activities and really trying to stay ahead of the curve. So I'm really grateful to our partners at the local health departments and the county leaderships that support them as well, because without that cross, you know, intergovernmental collaboration, we wouldn't have been able to get to where we are right now, which is one of the lowest infection rates in the nation. And we're watching what's happening around us. We are not letting our guard down. We learned, you know, from others and we continue to be as aggressive as possible in our response efforts and and learn from this one so that we can continue to refine those plans that that are there on the shelf, ready to be taken off and implemented and customized to the situation that we have. So thanks be for it. I appreciate that.

Jo Boufford Any time, just join the group. Any other questions for, before Mr. McCoy has to leave us ?

It's not a question that I just wanted to chime in on the same issue. So if there is a state of emergency, there's already a method in place for local health departments to assist each other. When New York City had the Legionella issue several years ago, Westchester County sent sanitariums in to assist them on their efforts to try to locate the source of the outbreak. Also, when there was measles last year, Rochester County sent nursing staff to Rockland to assist them. And when we were the first county to have a case of COVID, Rockland County sent staff to me to assist me. So it does happen. It is done. But I do agree that there would be nice at some point if we had a easier mechanism to make that happen. That's very helpful when it does.

Thank you.

Jo Boufford Any other questions? Thank you, Mr. McCoy, very much. Really important for us to understand public administration side of this. The county leadership side and this is obviously really complicated, I think, for many of the council members, I speak for myself. The deep the complexity of these relationships is something that obviously affects, you know, the ability to strengthen systems between the state and local government. Appreciate your joining us and you're welcome to stay.

Daniel P. McCoy Thank you and I do what I do as a Department of Health in working with people.

Daniel P. McCoy Again, it's easy just to point out the flaws, but I say this is the only way we're going to learn from this is knowing what went right and wrong and what you can do to fix it going into the future. But again, I thank you to everyone. I'm going to stay on as long as I can.

Jo Boufford Hopefully we'll see you again. Okay, Kevin Watkins.

Kevin Watkins All right, thanks, Jo. I'm going to give the panel and the council member a perspective from the rural county perspective. And I want to first say I want to thank Executive McCoy for his leadership down in Albany just to know that your commissioner of health has been a leader in COVID-19, for our state organization. And we really appreciate Dr. Whalen and her expertise. With that being said, I also want to just chime in on a question that also brought up by Yang about mutual aid. I do know that western New York, which consists of eight counties, actually do have mutual aid agreements and we have activated those agreements when necessary. We tend to have these agreements signed every five years, and we are working as a state association to move forward to make sure that more of these agreements are in place for our state association.

Kevin Watkins So with that being said, leading a rural community through COVID-19 can be somewhat daunting. Cattaraugus County has a population of less than 75,000 residents and a geographic area of one thousand three hundred twenty two square miles. The county has one hospital that has one hundred and sixty seven bed capacity, of which fourteen beds are actually designated for ICU patients. Now, getting the word out about COVID-19 through social media or website posts was beneficial for some residents, but located in areas or due to their religious belief, like our Amish population was disconnected to this type of technology and presented the county with its first barrier. There was the activation of our county emergency operations center where every department that is run by the county is represented and who were all involved in the COVID response in the COVID-19 information to our county residents. Resources like testing kits and PPE for residents, staff and medical personnel of Cattaraugus County was almost absent in the first two months of the outbreak. Locations like motels and hotels refused the reservation of any COVID-19 positive resident, leaving residents to have to quarantine or isolate in their homes with other family.

Kevin Watkins Initially, the health department home care nurses were asked to go out to the homes of symptomatic patients to collect COVID diagnostic tests.

Kevin Watkins The health department, along with the emergency operations center of the county, decided to open a drive through testing center in order to conduct all COVID-19 testing for COVID for county residents. We had to pull the local testing kits from hospital and our private medical offices of Cattaraugus County in order to open up the drive through testing site. As more residents were beginning to get tested, the department was under increased pressure to add an additional testing site, and the Northern part of the county has a number of residents who wanted COVID-19 diagnostic tests, could not get to the original test site due to lack of transportation or the long drive. Hence, a second testing site was open and the Northern part of the county and eventually a mobile testing unit was eventually set up in order to test our senior citizens housing buildings and our low income housing buildings. Both sites where staff are nurses and clerical staff from the health department. Other assistance was provided by our EMT from the Emergency Services Department, staff from the sheriff's department.

Kevin Watkins Now, when the governor when Governor Cuomo closed down schools and businesses, essential workers were still required to work.

Kevin Watkins In Cattaraugus County, there's been a racial makeup of the home can be two to three generations deep per household. Essential workers were coming home, unknowingly infecting vulnerable members of their family because they were

asymptomatic, asymptomatic. While there were no places for the positive person to go within the home in order to separate from others. Positive residents and their families were followed by the department's COVID response team, who conducted face to face visits in the mornings and telecommunication business in the afternoon. As positive cases increase face to face, visits were limited to only residents who had no band, internet or phone services.

Kevin Watkins So, for the most part, by daily departmental visits for COVID positive residents were conducted via telecommunication and by internet activity. Additionally, any resident who was placed under isolation received a set of quarantine or isolation orders. These orders are they were either given to them at the drive through testing site or they were delivered if they did not come through the drive through testing site.

Kevin Watkins Most of our families were self supporting. They did not require a lot of. Family members and friends dropped off food and supplies outside of their front doors. For those who needed assistance with food, medicine, animal supplies and animal food, the Health Department's environmental health staff delivered all necessary supplies to those quarantine residents. Residents who began to decompensate and needed to be hospitalized. The health department contacted nine one one four and pick up. When the health department was the only source for COVID-19 testing in the county, most health care providers would literally not see patients who were presented with COVID like symptoms unless a COVID test was done prior to the visit. Added more stress to the department's COVID response team daily duties. Because the response team had to decide when to send a patient with a history of COVID like symptoms in addition to other symptoms like chest pain, severe headaches, abdominal pains, shortness of breath and other emergency like symptoms to the emergency room. Now, telemedicine really opened up the ability for providers to reach patients. And it took some needed pressure off the department's daily workload. However, for those areas where there was no broadband or internet services, telecommunications or using telehealth services was not an option for a number of the homes in the county. Those patients were put off or suffered for scheduled appointments. I'm doing the shut down the businesses, schools and large gatherings and any non-compliant business was initially given a call, usually by our Department of Economic Development, who reminded them of the governor's executive order. And if a repeat offense did occur, a visit was made by our county sheriff deputy. If an illegal gathering occurred like our Amish schools continue to have sessions, Amish Weddings or Amish auction, a visit was made by the County Sheriff's Department and the illegal gathering's were dispersed. Most businesses did comply with the closure orders, but once the region moved to phase four of reopening, one or two businesses were very defiant. And New York State Police had to actually get involved in one and had to placarded the business. Plans to reopen schools were underway. The health director of my bordering county, Allegheny County, and myself attended several Zoom meetings with the superintendent. The department answered questions from the list of questions free attendance when we could not meet with the superintendents. The department has been in touch with several principals and school boards about testing, contact tracing and quarantine. The one university in the county has the department on speed dial, basically. I am personally in daily contact with the University Wellness Center medical director and the Vice Student Affairs. The department was the major consultant and their reopenings safety plans conducted their fit testing for their staff, tested their athletes, consultants and their quarantining of students prior to the start of classes and the list goes on.

Kevin Watkins This has been.

Kevin Watkins In history.

Kevin Watkins What we have learned from this; collaboration is key, communication is key and preparation.

Kevin Watkins We have not stopped preparing for the next wave.

Kevin Watkins Thank you.

Jo Boufford Sorry, I was on mute. Sorry, Sherlita. The questions are lining up, so let's hear from you, Sherlita Amler, and we'll open it to the council members for questions

Sherlita Amler Hi, I'm Dr. Sherlita Amler, I'm commissioner of health for Westchester County. Westchester is a county in close proximity to New York City. We have approximately one million residents. I think that one of the, I don't know which gentleman talked about the fact that we knew this was coming, that we could see it coming. But I think we have to remember that although we knew there was issues in China. We didn't know the natural history of this disease. And even when we saw cases in Italy and people were traveling to Italy from our county, coming back with concerns, we were unable to test them because the only testing that was being allowed at that time. Remember that CDC at that time was the only place in the country you could get a COVID test and they were only testing travelers who had returned from China. So even though we knew that we had people who had been in Europe, COVID, in Europe, we were not yet able to test for them. So if I look at what helped Westchester, because on March 3rd, we had the first case of COVID-19 in the state of New York. And in fact, I was called by State Health Department at one o'clock in the morning and told that we had a positive case in New Rochelle and an individual from New Rochelle and that the State Health Department would be in my county at 8:00 a.m. the next morning. And I should be prepared to have staff ready in full equipment and be ready to go out and start doing contact investigation and a sampling of any contacts that had occurred. So we actually were ready. At eight o'clock, m. My staff was there and we begin this operation. But how were we ready? And I think the reason that we were ready is twofold. One, in mid to late January, we started getting a couple of travelers from China and we were directed that these people, if they were ill, if they were coming in from a plane from China, from mainland China, then if they were ill, they were placed and had to be placed in isolation. And if they were not ill, they need to go into quarantine. And we had to designate locations where we could do isolation, quarantine. So we checked all our hotels. No hotels were willing to do this for the county. So we actually found facilities on county property where we could isolate quarantine, individuals returning. This meant that my staff needed to be fit tested. They needed to know how to wear and in ninety five at PPE, in ninety five maskin PPE appropriately. That we needed to know how to do testing because the testing would have to be done. Samples sent to New York State to then go on to CDC. So we had travelers and we and we had an opportunity to practice this before our March third case.

Sherlita Amler The second reason that we were in pretty good shape for knowing how to handle this kind of situation was that for the last nine years, we as a county have been working very closely with our assisted and independent living facilities around influenza norovirus outbreaks. Which meant that when we had outbreaks of those two infections in these facilities, we would send nursing staff and sanitariums into the facility. We would do line lists for those who were ill. We would assist them in getting testing for people who were exposed. We would send our environmental staff in to look at the facility, tell them what environmental changes they need to make in order to reduce the separate potential

spread of the infection and also taught their cleaning staff how to clean properly. And so a lot of these staff are not English speaking like the cleaning staff in these assisted and independent living facilities are not English speaking. Some of them can't read or write even in their own language. So you can stand there and talk to them in English and try to tell them what they need to do to make the facilities safe. But unless you actually can demonstrate it to them in an effective manner, they're never going to understand what you're trying to say. So a very important part of preventing spread in congregate settings is making sure that the environment is sanitized properly. Also, the use of green cleaners, although environmentally they're wonderful. When you have an outbreak, a lot of green cleaners will not kill a variety of viruses, including COVID.

Sherlita Amler So we have to make sure that the facilities have a list of cleaners that are EPA approved. And it lists the contact time and how the cleaners need to be used. And this is very, very, very important. It cannot be understated the importance of that for the facility. So we already knew all of our independent and assisted living facilities intimately. We knew their staff.

Sherlita Amler If they had any medical staff, we were aware of them. And this helped us have a headstart for those type of residential settings within our county. Of course, the state handles the nursing homes most of the time. So we really didn't have any background in our nursing homes, but in our independent assisted livings, we had a real heads up. So on March 3rd, we had our first case. As I said a week later, we went from one case and remember that we had no, there was no testing in the state at that point in time. So we sent nurses into the homes of all the contacts. It was a rather large group of people that needed to be tested. And we sent staff in to do the testing in their homes. Within a week, we had identified over 500 cases. And within the by the first by the next month on April 3rd, we had twelve thousand three hundred fifty one positive cases. Generally with communicable disease infections, how it's handle i. Is that you interview the case. You identify the possible source of the infection. You identify potential spread. Those individuals who may have been exposed could potentially become ill and spread the disease to others. And you you isolate them, you well, you isolate the case and you quarantine the contacts. But try doing that for almost 13,000 people in one week or one month. It's just not physically possible with a health department staff of about two hundred and twenty five people, that's just not physically possible to do t so. The county initially reached out and asked for volunteers from the community and we did get some volunteers to come forward. We had to train those individuals. The problem we have with volunteers, although it seems like a great idea, the problem was that the volunteers just didn't stay. We could spend two or three days training them and they may never come back. Although I will say that we had a small group of very dedicated volunteers that were very helpful to us. We reached out to other departments within the county workforce and actually our social service department had nursing staff that did come over to assist us. And they had investigators that they use in their child abuse division that were actually very skilled investigators and they were also very helpful to us. So we also tapped into our mental health colleagues because that was a major issue. And so we had a lot of support. I will say, from from other county agencies within our county. So as I said before, when this first started, we had no idea. We really didn't know what the incubation period was. We didn't know could you spread the disease if you had no symptoms? We didn't know what, you know and still don't really have a treatment. There was no vaccine. So the only way to try to contain this is through contact tracing and quarantine and isolation. That being said, through that first month, we were struggling just to tell people that they had a positive finding from their COVID test, more or less do contact tracing or any kind of investigation. I think some of the things that, as I said before, some of the things that helped us was

having PPE available to us and having people trained. But what one of the groups of organizations that had the most problem that didn't have the place was all of our other residential facility. So this is when all what we call the O residential places started coming into play. So the OPWDD, the Office for People with Mental Disabilities, their residential homes, the Office for Mental Health, residential facilities licensed by them, and the Office for Children and Family Services and their residential facilities. And we work very closely with them to help train, to train their staff to wear PPE, to actually get them tested once they have been medically cleared and with our Office of Emergency Services to provide them with the appropriate PPE. Very important because at this staff becomes positive. Is the problem not only put that facility, but a lot of these people work at multiple facilities. And so they were actually spread if became infected, they were actually spreading the infection not only at that facility, but potentially several others. We sent our own staff in to do testing of residents in those facilities and to get those tested, those people tested and potentially people placed in isolation, quarantine. I have to say that we had a lot of assistance from the state around trying to identify these facilities within our our community because a lot of them were not known to us. And so I think that going forward, having that knowledge is going to be a huge help for us. We already had a I think, a pretty solid relationship with our hospitals, our local medical providers. But there was a lot of organizations that reached out to us that we had not spent as much time maybe cultivating a formal relationship with, but we became the entity that everyone came to with their questions. So we certainly know the restaurants because we do their inspections and the places like barbershops, nail salons, gyms, schools, all of these places started bombarding us with questions and issues. And we had to try to be the trusted source for those for those agencies, for those facilities, for those small mom and pop companies or just storefronts as well. And I think our environmental staff played a huge role in going to these facilities and giving them advice. Also, municipalities, we work very closely with all of our municipal leaders. We actually had them calling about apartment buildings. We're seeing cases, large number of cases in this apartment building. Will you send staff in to talk to them about how they can clean their building? And we did. I do think to some degree that was actually very helpful for a lot of people. Schools, the schools didn't know what to do. When they started getting cases within their facilities the knee jerk reaction was, well, you know, we we need to close the schools. That decision is on them. I can't close the school for them. But what we could do was try to help them identify who needed to be in quarantine and isolation, who needed testing and help them make that happen. Eventually, the schools, as you know, were all closed. Now they're starting to reopen. And we actually just finished a Q&A for all of our schools that we have set out that we hope will help make the re entry back for the students and their parents a little bit easier by answering all of their questions related to; how are we going to do masking, how are we going to do social distancing, what's going to happen with testing, what if there's a positive case, is the whole school going to shut down, if for how long? A variety of questions, I'm sure we haven't answered all of their questions and I'm sure that we'll have to continue to work on that a lot more. Homeless shelters, there's a lot of unique populations in our county. And I think one of the most difficult that we had to deal with was homeless shelters, because we had people who were showing up at the hospital tested and positive who were homeless. And when they were ready to discharge, they were going back to homeless shelters. And these people were still infectious. So the county actually rented a hotel and we were able to then anyone who was homeless, who tested positive or needed to quarantine, were actually able and store to place them in a hotel room where the county will provide for any food, medications or other needs that they have so that they can safely maintain their isolation or quarantine. I think this has gone a long way to making our homeless shelters a much safer environment for everyone who is there. And I think the last point that I would make is around educating the public. As I said before, when this all

happened, we didn't know a lot in some of the things we initially said to people we had to walk back. If you remember at the beginning, we're telling people, oh, you don't need to wear mask. The only people need to wear masks or health care workers. And then it became apparent that everyone wearing a mask did a lot to help prevent the spread. So we still have people who say, but you tell me, why do I wear this? You guys said we didn't need to wear this. It's all in how we provide the information to the public and sometimes when we have to change it, we have to just be upfront and say, you know what? We don't know everything. What I know is what I know today and I may have to change what I'm telling you tomorrow. So, you know, I'm giving you the best advice I have at the moment. And we continue to do that for the public and for our medical community. And I think that just having all of these relationships of working very closely with our entire community, because we're where they come to when they have a COVID question. We've worked very hard to build the trust. And I think we have established relationships that are going to last for us long after this event is over, I hope. Thank you.

Jo Boufford Thank you very much. That's great. Thank you so much. We're open for questions for any other panelists. Dr. Gutierrez has a question.

Dr. Gutierrez Thank you. Thank you very much. It's a common question for Dr. Watkins, first.

Dr. Gutierrez And the only person I know personally know who has died of COVID-19 was a reservation. Where his household, an entire household was affected by it. There were three deaths in the household and another two other people that were really sick and recovered. You mentioned the Amish people as an isolated thing.

Dr. Gutierrez Please tell us about the Indian reservation and what kind of relationship you have with them.

Kevin Watkins I had a pretty good working relationship with them as well. We met every, I met with their medical director, at least daily on my health directors brief that I did with our hospital and our medical provider. The situation in which you are talking about really it really bears a lot of I don't know, we would call it a lot of pain for the community because we did lose five residents due COVID-19. And four of them were actually from the cynical nation of Indians, one of which you talk about. That was three and one family of which we had three of one family that actually died, but the entire family actually tested positive. And so when I talk about having generations of family members in the home, this is a prime example of that. Where one essential worker went out to work and he came home. And we are, as we can only speculate that he was the one who infected the entire family.

Kevin Watkins With that being said, they were very cooperative with the health department. We provided them with a data regarding a number of Seneca nations, that residence that were actually tested and those that were actually testing positive. Those that were tested negative and we provided them with needed testing kit. When we finally did get testing kits, they eventually bought a rapid tester to to test their community.

Kevin Watkins But like most commercial laboratories, they just were not able to buy, but they weren't able to find the supplies like reagent in order to run that rapid testing.

Kevin Watkins So they still had to come through our drive through testing sites that we had available, but we worked very closely with them to answer your question.

Dr. Gutierrez Thank you.

Jo, I think you're muted.

Dr. Brown, sorry.

Dr. Brown Yes. Again, another wonderful panel. And I really appreciate it. For the first time, I get to ask a question of Dr. Watkins because he's usually on our side of the table. But hopefully enough, in all seriousness, I've heard from one of the panelists that you wanted to what I've heard, it will change the relationship between the local health authorities and the New York State Department of Health in terms of responsiveness and authority. So I'm not sure whether that's something that really is also a legislative fix or something. I don't know.

Jo Boufford Sarah, I think that was your point. Ravenhall, in terms of a particular emergency situation. Can you clarify?

Sarah Ravenhall That is a regulatory recommendation we have. So currently the commissioner of health has the authority to step in and take over locally and utilize the local health department staff and resources. And we'd like to see that regulation go both ways. So not only can the state do that, but the local health department should also be able to step up and say, I've got this public health emergency and we need support from the State Department of Health. And one of the reasons we think this is so critical now to see a regulatory change now is because we first see further reductions in the local health department workforce due to cuts in funding budget at both the state, federal, state and county levels.

One of these is a professional difference between the local health authority and the state? Have you given some thought to how that would be resolved?

Ask ask one more time, I'm sorry. I want to make sure I'm understanding.

No problem, I wondered if you had thoughts about what if there is a difference.

Profession and the opinions between local health. I think I know the answer. But just in case, I want to give your response and the New York State Department. Are you just asking to be heard? Are you just asking to, in fact, have more than just to be heard?

Well, I, I, I think that does happen.

But I do I we follow State Department of Health guidance in this situation. I think this is really just a matter of resources. And we have a great relationship with the State Department of Health. They definitely hear us out and we work collaboratively on different policies. So it's not necessarily an issue of a disagreement on approach. It's more about we know that there are strapped resources in the public health landscape and we want to be as efficient as possible. And the regulations should go both ways vs. the state being able to step in and the local health department.

Thank you.

Does that? Okay, I hope I answered that. Thank you.

Jo Boufford Laura, do you want to say anything?

Laura Thank you for giving me one second to get off the double mute with the technology here and then get back on camera. So, yeah, I agree with Sarah. You know, we work very collaboratively, collaboratively together. It is the home rule, you know, with the counties being able to do as much as possible. But for especially in a pandemic, it's really important to have consistency. And I think that's something that Executive McCoy mentioned, is that very early on, decisions were made up, a highest level for that consistency, so that there was, you know, the same response across the state, so that was really important. But as Sarah knows and as she mentioned, we're on the phone constantly and she's been a great conduit to the local health department members to be able to say, okay, this is where we have to go with this. You know, what is the membership think? And they give us all the different ideas. As she mentioned in the very beginning, when you've seen one local health departments, one local health department. So one decision is never going to be met with a resounding, you know, agreement across 57 counties. It's just not going to happen. But in order to manage something so tremendous, you do have to have those state level, you know, consistent across the board type policies that may not always match. The locals are always able to go strictly oftentimes, but as long as it doesn't in some way inhibit a state wide response. So, you know, we worked very delicately. And I think what they're really referring to in particular is the ability to, at the state level, come in and manage your response locally. And that's something that's really intended when the local health department can, you know, as you will say, we try not to do that. There's no reason to because the local health departments know their community best. But in the state perspective of being able to protect all communities, I think that's where that language is coming from.

And there may be a time that we want that to happen, we may need the state's help. And so the regulation change that we're recommending is to just let the local health departments step up to the Department of Health and say, you know, we just don't have the staff for that for for this whatever is going on in our community and we need your support.

And I was staring at more of a resource issue of taking resources that, you know, so that's a really important part. I think Sherlita wanted to comment on this point and has a question.

Sherlita Amler If I could add, I've been in that situation a couple times where we've had an outbreak of whatever the condition was. It's happened twice since I've been in Westchester, where we just didn't have the technical skill set to manage the investigation. And both times I reached out to the state, I asked them for assistance. And both times they came in and they granted that assistance to us. It worked beautifully. I think the concerns are we you know, the people that are in leadership now, and I think most of the commissioners work very well together. Historically, that has not always been the case. And who knows what could happen going forward. So I think that we would just like to memorialize the relationship that we have now, which is working so well for us. And so that going forward, we will have that same support and they as well. Because when this all happened, they asked for our county support around the first case of COVID. We were there. We did everything they asked us to do, largely in part because when we needed help, they've done the same for us.

I just I just wanted to clarify that I'm understanding this correctly. What you're asking for is in certain circumstances for local health departments to be able to ask the State Health

Department to second staffing resources, but not see the state statewide guidance aside, but not see local authority.

Correct, that is correct.

Dr. Amler, you hit the nail on the head. Thank you.

Good clarification.

Jo Boufford Are there any other questions from members of the council? Anne Monroe and then Scott LaRue.

Anne Monroe Thank you. One of the things that I'm interested in understanding now that schools are having to make decisions about whether they go back is how you are working with them around the issue of testing. And also, if you have explored relationships with the primary care safety net in your communities to be partners with you in meeting those testing demands, what kind of dialogue are you having? Do you see it as a three party thing? The schools, the health department and the community safety and I'll take a comment from anyone.

Well, I can tell you what we're doing in Westchester in that I have way too many students to be able to test every student and every teacher in Westchester County. So the schools are responsible to come up with their own testing plan. Where we will come in is if there is an outbreak and if there is the need for us to go in and test specific individuals has a relation to cases that may occur. We will assist them with that, but we do now have the resources to do more than that.

Anne Monroe Thank you.

And I know if I could just add to that. And the same for us basically is that we are asking our schools to withhold from request the health department to come in and test their entire staff and the students as they feel as though a baseline is required for a school to begin. We have discouraged them to do that, to inform us if there is a symptomatic resident or symptomatic staff and or a student that needs to be tested, that we can send them through our drive through testing site and have them that way. But to just do an overall testing for the entire school district and the university, we think that it's just notifying obsolete.

And if I can add one more thing, it's important to remember that because some schools want to do their own testing, but in order to do testing, you really do need to have somebody in an in ninety five mask doing the testing. If you're going to stick a swab up somebodies nose, they may cough or sneeze on that person. And so these individuals to do fit testing to wear it in ninety five is not just you put on it in ninety five, it means that you've been medically cleared to wear that mask, that you have been tested to that particular mask. If the mask isn't, it is no longer available and a new mask is obtained. You have to be refit tested to that mask. So it's very important that people understand that for residential facilities, for schools, it isn't. You just stick somebody in and in ninety five mask. There's a lot that goes with that. And they need to have sufficient supplies of that mask when they get to get their staff tested. Otherwise, you're wasting your time.

Okay.

Jo Boufford Mr. LaRue And then Mr. Lawrence and Dr. Gutierrez, last question we'll have to wrap up.

Jo Boufford Scott.

Scott LaRue Thank you, Dr. Boufford. I had a question for you. You mentioned the travel restrictions and residents from Westchester are coming back from, say, Italy. Was it your experience that this was a coordinated effort? And were you getting notified that there were residents of Westchester who came to the airport and that they were being screened? I certainly had employees who came back from Italy after the restrictions, and their experience was that no one asked them a single question at the airport.

No, the only people who were being screened at the airports were travelers who were returning from China and our travelers to and to some degree. If they diverted themselves, if they were from mainland China to someplace else and then into the United States, they could have gotten missed then, too. So what happened was once the cases started mounting in Italy, we had a lot of people, a lot of families who had taken spring break and went to Italy with their children. And when they came back, they wanted to be tested. And at that point in time, there was no test, that was in February, there was no ability to get them tested. Because the only testing mechanism was CDC. And they weren't testing people who were returning from Europe at that time. So we couldn't get them tested and subsequently, a lot of these people then later, when testing was available, went and got antibody testing to see if, in fact, they had had the disease when they were there in February.

So, no, an opportunity just didn't happen.

Thank you. And just a second quick question. You know, I appreciate your comments about the testing and the N95 mask. You know, my experience was I couldn't get a testing kit from the end of February to one arrived from Amazon the first week of May. Did you have access to testing kits? And if so, where did you where were you getting them from?

So as I said before, we've been working with our assistant, an independent living facilities, for the last nine years. Part of that is that, you know, we want them to have staff that are available to wear N95's should they have to deal with people who are ill, who have influenza. We don't want the staff getting sick and moving it on to other people. So we as as a county have we have the equipment to fit test people. The health department, we have the equipment. And so we in the past have offered that to our staff of these facilities. So they come to the health department. They have to have the N ninety five mask available. Most of the time, that's how it's worked. They come in with a mask that their facility has purchased. We fit test them so they're safe to work and not spread disease within their within their organization. And I really think that this is if we want to prevent a second wave, these organizations, all these residential facilities, whatever they are, they need to be testing their staff and they need to have in ninety five masks available and would go a long way to preventing the spread of disease in residential settings.

Jo Boufford Mr. Lawrence.

Jo Boufford You're on mute.

Mr. Lawrence Thank you. Great presentation.

Mr. Lawrence And I guess I was sitting here listening to both of you and especially Dr. Watkins, and lamenting the problem with a quantity of people at all the hotels and attempting to find a place where you isolate infected individuals.

Mr. Lawrence I think it comes it's critically important. It should be emerging infection.

Breaking up.

Mr. Lawrence You can't hear me?

Whatever you're doing right now, it's fine.

Mr. Lawrence Okay, I shall start over again. I think I was listening to the presentations and the whole notion of having to call hotels to find a room warranty and an exit and getting phone.

Mr. Lawrence I knew and had no available room seems to be a problem, especially in emerging pandemic. So I'm just questioning whether that part of the problem has been resolved. And then second, whether there are things within emergency statutes that require searches have to open up their defense for this purpose.

I don't know if Brad or Laura wants to take that question, but I'm not sure that that problem has been resolved, at least on our end. And that wasn't that the rooms were not available because there were no traveling, occurring, doing, you know, starting in March. And the hotels were pretty much empty, but they refused to take any COVID at those positive patients in those facilities.

I think it would be a great idea if there was a way that local health departments can commodore those hotels and use them for facilities to isolate a positive residence so that those residents would not have to go home and possibly infect other members of the household.

Brad, do you want to?

Brad I'm happy to, I think it certainly was the case in March that hotels were reluctant to take on either an individual who was in need of isolation or a contact to his quarantined. I think we're in a much different situation now. You know, as we have colleges returning and the need for students who are coming from impacted states who might need to quarantine. I think hotels are really seeing that as an opportunity to fill their rooms. They're much more comfortable with the disinfection guidelines that we released in March or April. So I think we are in a much better situation where we have already capacity to handle individuals who are in need of quarantine and even potentially isolation. I mean, ideally, we want to isolate or quarantine somebody at home where they're comfortable to be for two weeks. You know, we only want to use a hotel as a last resort, but I think we're in a much better place.

But, Brad, I guess the question is from a statutory point of view for the council, which is something I know you're doing a lot of mobilization and requirements of hospitals to cooperate and other things. Is this an area that ought to be looked at a bit more other than just letting people when they get comfortable doing it as opposed to if you really needed it?

You know, I'd have to talk about that with counsel. I mean, we certainly have both local and state health department broad authority to compel certain actions when there's a public health need for that. But I think we would always want to work to secure voluntary participation in something like quarantine or isolation and well, it was very challenging. You know, like I said, I think we're in a much better place and we have numerous establishments willing to voluntarily make their room capacity available.

Do you guys agree?

I do agree. And in fact, Westchester, what we ended up doing is because hotels were hesitant because they thought the public would not want to come. There was they knew there were people with COVID being housed there. So we just rented the entire hotel. We found a hotel where we can rent the entire hotel that we didn't have to worry about people potentially being accidentally exposed.

If I may also provide additional leverage to can we encourage people to act in a way that is beneficial to the public without, in fact, using it. I think this is something that should be considered because this time around in scope, it may have been it had been all of us and something else that's much more deadly.

And so I think it's something we should consider.

We can follow up on that. And let me just let Dr. Gutierrez last question, because we're running out of time.

We've run out of time, actually.

Dr. Gutierrez So as a physician and a member of the council, I confess that I have been perplexed with the abdication, the cascade of abdication of responsibility. And if I am perplexed, I suspect that the common individual outside is perplexed by our inability to take charge and manage what happened. I heard Ms. Amler or Dr. Ambler say that at one point she had to tell the school, we cannot test you. You're gonna have to figure out a way. I mean, really, I understand that I am not criticizing you. I know you are in a very tight situation. But the federal government abdicated on the states. The states are not abdicating. You know how we end up looking to the population in general. We are fumbling with this and regaining the prestige on that direction is going to take a long time. I'm sorry, but that's what I think we're gonna have to live with. That's it.

It's obvious that you no, I mean, I think it's that important point that's very complicated point. I don't think we as a council have really the first conversation I've been involved with in discussing, you know, this these intergovernmental relationships. I think that we're we're hearing from colleagues as the partnerships before the crisis are really crucial. But it's fair enough to say that if the authority if the authority needs to be clarified, we should talk about that some more and see if there's a role that we might play. I think it's been really, really challenging, given the lack of a sort of federal clarity and leadership for sure. You're absolutely right.

Jo Boufford Shelita, you want to jump in at this point or?

Sherlita Amler About about school testing. First of all, you know, there are issues with just testing everyone. The schools need to understand when testing is appropriate, which is what we're trying to help them understand. And we know now from PCR testing that you

can remain positive by PCR long after you are no longer infectious. But if you test and your PCR positive, even if you have no symptoms, unless I can document that you've had a recent positive test that I know this is not a new infection, you're now placed in an isolation. So there's needs to be dialogue with the school so they understand what the testing will get them and what it won't get them and what problems they could create by testing people that are not symptomatic, that have no history of exposure. And so it's not as simple as, you know, tests or not test. This is a very complicated and and that, you know, they could just say, okay, we're going to test everybody. But that takes testing away from people who actually need it. It increases wait time when you test a whole lot of people that really don't need to be tested. You're increasing the wait time for those people who do because there's a limited amount of reagent. There's a limited amount of labs available to do this. And so we need to be smarter in what we do and less reflexive in what we do. And I think we've learned enough to do that.

And I think part of the message of this conversation is the importance of local relationships. But at the same time, consistency in messages to be communicated. So it is, you know, not one or the other, not not not easy answers to these. But I really appreciate everybody who has contributed. It's been a terrifically open and good dialogue. I think, you know, complements to our colleagues at the state for what you've done in tough, tough circumstances. And you've opened some ideas, I think, for the council members to look at in regard to the sort of overall public health infrastructure which we all along with links to primary care, which we're really our focus for this morning.

Jo Boufford So thank you all so much for your involvement. John, I don't know if you have any last words?

John Rugge I'm open speaking. No, I think I think this has been quite a day and I really appreciate all the other work going into it.

John Rugge But also, especially all the presentations are really nice.

Jo Boufford We're looking forward to the 19th and hopefully to gathering themes, as we've said from today's work, to go forward with with further conversations with the council and potentially action as it emerges as the clarity emerges.

Jo Boufford Jeff, you're our chief, do you want to bless us as we go off into the sun.

Jeff Kraut You know, it's a fascinating conversation, Wide-Ranging topics from your occlude this morning as well. And I think the challenge is to distill these things out instead of, you know, just kind of rehashing problems is how do you propose solutions, as you've said.

Jo Boufford If we all answer Dr. Brown's questions will be very well organized or we'll try to do that in the transcripts, if not from the speakers, so.

Jo Boufford Okay, thank you very much. Appreciate it.