FINGER LAKES REGIONAL PLANNING CONSORTIUM

Board of Directors

AGENDA

September 11, 2020 1pm-3:00pm
Gotomeeting Conference Call

- **Call to Order & Welcome** – Margaret

- **Roll Call & Confirm Quorum** – Beth

- **Approve May 15 Minutes** (attached) – Margaret

  - Motion
  - 2nd
  - Discussion or Corrections?
  - All in Favor? Any Opposed?

- **Welcome New Board Members** Margaret

  - Christopher Bell. Executive Director, Monroe County Medical Society
  - Lindsay Gozzi–Theobald, Chief Program Officer. Villa of Hope
  - Claire Isaacson. Manager of Case Management, Molina Health Care
  - Denise DiNoto, Director of Community Services, Rochester RHIO
  - Steve Harvey, President, Integrity Partners (BHCC)
  - Lisa Smith, Interim Executive Director, Finger Lakes and Southern Tier BHCC

  Updated Board List Attached to Meeting Materials

Questions? *Contact **Beth White, RPC Coordinator** at bw@clmhd.org or 518-391-8231 or **Margaret Morse, RPC CoChair** at mmorse@co.seneca.ny.us*

Finger Lakes RPC Board Meeting Agenda – May 15, 2020

- **FQHC Nomination to Board** – Jordan Health (see attached Bio) Margaret
  - Motion
  - 2nd
  - Discussion or Corrections?
  - All in Favor? Any Opposed?

- **Albany CoChairs Meeting Preparation – October 29** Margaret

- **Black Lives Matter** Beth

  Intersection with RPC's Work

  Client Impact

  Approaches for Supporting BLM in rural areas

  Supporting Law Enforcement – how can we increase support to them in working with people with mental health problems? Does CIT training address racial inequities?

  Staff Impact

  Stakeholders' Current Initiatives

  Attached Resources:

  - Hard Facts: Race and Ethnicity in the Nine County Greater Rochester Area
  - SHRM Tips for Discussing Racial Injustice in the Workplace
  - Racial Equity Tools Tip Sheet: How Can We Avoid Blaming the Victim….?
  - Research Addressing Racial Disparities in Mental Health Treatment
  - Greater Rochester Black Agenda Group - DECLARATION: "RACISM IS A PUBLIC HEALTH CRISIS"

- **Future of Telehealth** – Margaret

Highest Ranked TH Factors in Survey (for Importance and Regional Work Viability)

Client Satisfaction
Retention of Telephonic Modality
Development of Clinical Guidelines – Indications, Contraindications, Best Practices
Workforce Ramifications
Rates, Permitted Time Intervals & Frequency of Visits

Factor Selected & Referred to Clinical Integration Workgroup

Development of Clinical Guidelines
Indications, Contraindications, Best Practices
Permitted Time Intervals & Frequency of Visits w/Viable Rates

- **BHCC Updates**

Finger Lakes and Southern Tier BHCC – Lisa Stauch Smith
Integrity Partners for Behavioral Health – Steve Harvey

- **FLPPS – STACI process**

System Transformation and Community Investment – Nathan Franus

- **RPC Activities** - Beth

RPC Q2 Report (attached)
Children & Families Subcommittee – met August 3 – 53 Attendees
Children starting to tire of TH visits
Exhausting for staff to do 8 hrs/day TH visits
Concerns about not being able to be on-site in schools in fall
Still much confusion about how to use OLP services and the difference between a referral and a recommendation, need for more education and outreach to community allied health providers
CFTSS/HCBS Sustainability Learning Collaborative almost wrapped up
Bed Finder Migration to North Country/Tug Hill continues

- **Next meeting** Beth

  Friday, November 13 from 1-3pm - GoToMeeting

- **Wrap Up & Adjournment** – Margaret

Finger Lakes Regional Planning Consortium
Board of Directors Meeting
Minutes

September 11, 2020 - 1pm-3:00pm
GoToMeeting

- **Call to Order and Welcome** – Margaret
  - Moment of Silence in Remembrance of September 11th
- **Roll Call and Confirm Quorum** – Beth confirmed meeting and voting quorum present
- **Approval of May 15, 2020 Minutes** – Margaret
  - May 15, 2020 Minutes approved
    - Sally Partner - Motion
    - Lori VanAuken - Second
      - No discussion
      - No opposed
      - All in favor
      - Steve Harvey – Abstained
- **Welcome New Board Members** - Margaret
  - Christopher Bell. Executive Director, Monroe County Medical Society
  - Lindsay Gozzi–Theobald, Chief Program Officer. Villa of Hope
  - Claire Isaacson. Manager of Case Management, Molina Health Care
  - Denise DiNoto, Director of Community Services, Rochester RHIO
  - Steve Harvey, President, Integrity Partners (BHCC)
  - Lisa Smith, Interim Executive Director, Finger Lakes and Southern Tier BHCC
- **FQHC Nomination to Board –** Jordan Health – Margaret
  - Melissa Wendland – Motion
  - George Roets - Second
  - Unanimous vote among eligible, voting members
  - Motion approved
  - They will join at the next meeting in November
- **Albany Co-Chairs Meeting Preparation for October 29th** - Margaret
  - Co-Chairs and Coordinators for the 10 RPC regions and New York City, meet with state leadership from DOH, OMH, OASAS, and OCFS

- Break-out Sessions
  - Value Based Payment and Managed Care Organizations
  - Peers and Workforce
  - Children and Family
    - Clarified – this is not an open meeting

- **Black Lives Matter** – Beth
  - Resources
    - Hard Facts: Race and Ethnicity in the Nine County Greater Rochester Area
    - SHRM Tips for Discussing Racial Injustice in the Workplace
    - Racial Equity Tools Tip Sheet: How Can We Avoid Blaming the Victim….?
    - Research Addressing Racial Disparities in Mental Health Treatment
    - Greater Rochester Black Agenda Group - DECLARATION: "RACISM IS A PUBLIC HEALTH CRISIS"
  - Intersection with RPC's Work
  - Client Impact
    - What are your agencies doing to address the issue?
      - Mandy – death of Daniel Prude called out the importance of MH Crisis Response
        - Includes those with addiction issues
        - Structural racism
        - Everyone is impacted
        - RRH having conversations with clients, staff, the system, and the community
          - Any way the RPC could assist?
            - Not sure
            - Table confusion – who's addressing what?
      - Craig – working with those having co-occurring disorders
        - Some focus on Quadrant 4 individuals with increased levels of Mental Health and Substance Use Disorders.
      - Lori – important to have these conversations because of the positions held within the community and the ability to do something but it must be germane to the conversation
        - Agrees that there is table confusion
      - Melissa – racism is a public health issue effecting marginalized communities
        - Part of the collective effort
        - How to work with communities in regions
        - Importance of who is delivering the message (RPC)

- Approaches for support in rural areas
  - Melissa – elevated conversations among marginalized communities
    - Programs and initiatives effecting 60 – 70% depressed, socio-economic areas
    - Social determinants of health
    - Starts with leadership
  - Jennifer – House literacy course on public health perspective, heath literacy, and cultural competency of care
    - Will be emailed out
- Supporting Law Enforcement – how can we increase support to them in working with people with mental health problems? Does CIT training address racial inequities?
  - George – decades of promise of continuum of care
    - Defaulted to police but haven't developed those types of crisis programming to complete the system
    - 7,000 mental hygiene arrests in Monroe County, to date this year
    - People are not equipped to serve within the community
    - Person arrested but quickly released – needing to address our responsibility in that and develop real partnerships
  - Margaret – CIT Curriculum
    - Implicit bias is touched upon
    - Dealing with the whole person, including the racial and social makeup
    - Single-person oriented
    - Does it also address the bias of the individual police officer?
      - Not necessarily
      - It stresses the police needing to know the makeup of their community and that some will be the same as them, but others will be different – treating everyone the same
    - Recruitment of officers for who they are and why they want to be police officers
    - Social work role falls on police – how to engage with the community which is a lot of what the role involves
    - Military organization with lots of rules
    - Need to build a continuum of care and not have holes in the system
    - CIT having the right people to the problem
    - How do we cut-down on calls to the police?
      - Treatment first
        - Yates County

- Mary – Broome county has diversion with 911, engaging in next steps
- Margaret – reinvention of law enforcement efforts underway statewide – critical for BH leaders to be at those tables and participate in this process
    - Reforming policies in Seneca County
    - Engaging the community in public forums
    - Effective efforts at diversion
- Kelly – Monroe County
    - Not all officers are not mandated to attend the training, only 20%
- Brian – emphasized pick-up order as a moral obligation, vs. a legal obligation
- Melissa – health disparities often at their worst in Black and Latino communities
    - Exacerbated by poverty
    - These communities are up to 3x more likely to live in poverty

- **Future of Telehealth –** Margaret
    - Key Takeaways
        - Everyone - clients and providers, want the telephonic mode of Telehealth to be retained and the State is working to make that happen – it has significantly addressed access issues caused by lack of transportation and/or broadband resources
        - This valuable modality will only be sustainable with the continuation of viable rates – there is intense concern that, post-COVID, rates may be reduced to an unsustainable level
        - Continuation of the flexible permitted time intervals will be important – practice may evolve to more frequent, but shorter, contacts with clients – doing this has increased engagement with some clients
        - Request for the State to be deliberate in moving toward uniformity in regulations across MA agencies
        - While the telephonic mode is extremely valuable, there are some clients and circumstances in which it is not always the best modality
            - New Clients, in some cases
            - Some Youth
            - Some Clients with Substance Abuse disorders
            - Assessments evaluating Risk for Harm
            - Situations where abuse is a concern - child, family, or partner
            - Presentations where visual observation is needed or preferable
        - Survey Results – ranked on importance and regional work viability
            - Client Satisfaction
            - Retention of Telephonic Modality

- Development of Clinical Guidelines
- Indications
- Contraindications
- Best Practices
- Workforce Ramifications
- Rates, Permitted Time Intervals, and Frequency of Visits

▪ Rochester Regional Health Telehealth Overview - Presentation by Mandy Teeter to workgroup – provided valuable framework for assessing implementation & issues
  ▪ RRH identified large volume of "meaningful contacts" with clients that are not billable and have collected data - Will share with group once information is received
▪ Highest Ranked Telehealth Factors in Survey (ranked by workgroup for Importance and Regional Work Viability)
  - Client Satisfaction
  - Retention of Telephonic Modality
  - Development of Clinical Guidelines – Indications, Contraindications, Best Practices
  - Workforce Ramifications
  - Rates, Permitted Time Intervals, and Frequency of Visits

From the above ranked items, the following are referred to the Clinical Integration workgroup:

- Development of Clinical Guidelines
- Indications, Contraindications, Best Practices
- Permitted Time Intervals and Frequency of Visits with Viable Rates

o Clinical Integration & Practice workgroup
  ▪ In light of new issues being referred to workgroup, the purpose of workgroup is to be expanded to address clinical practice versus just integration
o Next steps
  ▪ Convene Clinical Integration & Practice workgroup
  ▪ Since there has been lots of interest, meeting information will be sent to the full board in addition to current workgroup members

- **BHCC Updates**
  o Finger Lakes and Southern Tier BHCC – Lisa Stauch-Smith
    ▪ Agency level – how to use data to drive best practices and quality improvement projects

        - How to support those within the network
    - Integrity Partners for Behavioral Health – Steve Harvey
        - 14 LGU and 10 Community Based Providers
        - Partner with the UB School of Social Work
        - Data warehouse – comprehensive data analytics
        - Data points understand cost
        - Fiscal monitors
        - Stronger effort to connect partners
        - Sharing expertise
        - Referral module – to launch the week of September 14th with the treatment services closest to you
        - MAT project – OASAS funding model with 8 providers - successful

- **FLPPS – STACI process**
    - System Transformation and Community Investment (STACI) – Nathan Franus
    - How should FLPPS invest the remaining $3 million – poll of community focus groups
        - Objectives
            - Build upon the principles of DSRIP by using data-driven and transparent inputs to identify high-value and high-impact programs that support region-wide collaboration
            - Continue and scale DSRIP "promising practices" across the following domains:
                - Behavioral Health
                - Maternal and Child Health
                - Social Determinants of Health
                - Care Management
            - Social Determinants of Health, Care Management, Telehealth, Workforce, and addressing health disparities will be considered throughout all domains
    - Needs Assessment and Methodology
        - Using data driven approaches to inform future decisions
    - Funding – money remaining from the DSRIP project
        - Working with partners to deploy these interventions – hope to complete by the end of the year
        - Prioritize areas by ranking criteria
        - Data ends June 2019
            - Margaret - Integrated clinics – data is wonky because the metrics do not necessarily reflect services provided

- **RPC Activities for Quarter 2 –** Beth reviewed the Finger Lakes Q2 Report
  - RPC Areas of focus
    - Behavioral health work force
    - Children and family
    - Innovations in value based care
    - Social determinants of health
  - Mental Health Access Survey
  - Behavioral Health Crisis Resource Guide
  - COVID-19 TeleMental Health Tracker
  - Quarter 2 – Top Issues
    - Physician Assistant (PA) Scope of Practice in Article 31 Clinics – cannot assess or prescribe without completion of OMH waiver process, resulting in an important workforce resource unable to fully deliver critically needed services to clients
    - Children & Families providers report CFTSS/HCBS services not financially sustainable
    - Residents of 820 OASAS housing programs are losing Managed Care insurance due to a processing problem at LDSS around the Congregate Care Level 2 application.
  - Next Steps
    - Confirm Status of new Physician Assistant Psychiatry Track Curriculum at RIT which may result in PA's being permitted to prescribe in Article 31 Clinic without needing the currently required OMH waiver process
    - Convene closing session of CFTSS/HCBS Sustainability Learning Collaborative
    - Survey Learning Collaborative participants on the value of the learning tool & the Collaborative experience
    - Follow-up with regional 820 OASAS providers to gauge success of the implementation of the formal GIS notice intended to correct the interruption of clients' Managed Care coverage
  - Achievements and Upcoming
    - Finger Lakes Crisis Resource Guide issued – Apr 29
    - Convened First Meeting of New Finger Lakes RPC Workgroup – Future of Telehealth
    - As a direct result of the work of the WNY RPC, with advisement and support from the Finger Lakes RPC, NYS DOH, OTDA and OASAS jointly issued a formal GIS notice to Local DSS Commissioners correcting the interruption of clients' Managed Care coverage when they are admitted to OASAS 820 settings

  - Next Steps
    - Meet new physician leader for the RIT Physician Assistant program to discuss their curriculum for new psychiatric PA certificate and the potential to connect with OMH early in hopes of graduates being exempt from current OMH waiver process

- Children & Families Subcommittee – met August 3rd – 53 Attendees
  Children starting to tire of Telehealth visits
  Exhausting for staff to do 8 hrs/day TH visits
  Concerns about not being able to be on-site in schools in fall
  Still much confusion about how to use OLP services and the difference between a referral and a recommendation, need for more education and outreach to community allied health providers

- CFTSS/HCBS Sustainability Learning Collaborative - almost wrapped up

- Bed Finder Migration to North Country/Tug Hill continues

- **Next Meeting –** Beth
  - ***Friday, November 13*** from 1-3pm – GoToMeeting

- **Wrap Up and Adjournment** – Margaret
  - Adjourned at 2:54 P.M.

FINGER LAKES REGIONAL PLANNING CONSORTIUM

WELCOME

FINGER LAKES RPC

9/11/20 Board Meeting

Call to Order & Welcome – Margaret

Moment of Silence for All Those Who Lost Their Lives or Loved Ones on September 11, 2001

FINGER LAKES RPC

9/11/20 Board Meeting

- **Roll Call & Confirm Quorum** - Beth
- **Approve May 15 Minutes** Margaret

FINGER LAKES RPC

9/11/20 Board Meeting

Welcome New Board Members!

Margaret

- ***Christopher Bell,*** Executive Director, Monroe County Medical Society
- ***Lindsay Gozzi–Theobald,*** Chief Program Officer, Villa of Hope
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- ***Lisa Smith,*** Interim Executive Director, Finger Lakes and Southern Tier BHCC

FINGER LAKES RPC

9/11/20 Board Meeting

Nomination to Board - Margaret

Jordan Health – FQHC

HHSP Stakeholder Group

FINGER LAKES RPC

9/11/20 Board Meeting

Albany CoChairs Meeting - MM

October 29, 2020

CoChairs and Coordinators of All 10 RPC's and NYC RPC meet with Senior Leadership of 4 State Medicaid Agencies

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DOH, OMH, OASAS, OCFS

FINGER LAKES RPC

9/11/20 Board Meeting

Black Lives Matter - Beth

Intersection with RPC's Work?

FINGER LAKES RPC

9/11/20 Board Meeting

Black Lives Matter - Beth

Intersection with RPC's Work? Discussion Points

- Client Impact
- Approaches for Supporting BLM in rural areas
- Supporting Law Enforcement – how can we increase support to them in working with people with mental health problems? Does CIT training address racial inequities?
- Staff Impact

Stakeholders' Current Initiatives?

FINGER LAKES RPC

9/11/20 Board Meeting

Black Lives Matter - Beth

Resources included in Meeting Materials

- Hard Facts: Race and Ethnicity in the Nine County Greater Rochester Area
- SHRM Tips for Discussing Racial Injustice in the Workplace
- Racial Equity Tools Tip Sheet: How Can We Avoid Blaming the Victim When We Present Information….?
- Research Addressing Racial Disparities in Mental Health Treatment
- Greater Rochester Black Agenda Group - DECLARATION: “RACISM IS A PUBLIC HEALTH CRISIS”

FINGER LAKES RPC

9/11/20 Board Meeting

Future of Telehealth Workgroup - MM

Identified, Discussed, and Ranked Key Factors in Telehealth

Key Takeaways:

- Everyone, clients and providers, wants the telephonic mode of telehealth to be retained and the State is working to make that happen – it has significantly addressed access issues caused by lack of transportation and/or broadband resources
- This valuable modality will only be sustainable with the continuation of viable rates – there is intense concern that, post-COVID, rates may be reduced to an unsustainable level.
- Continuation of the flexible permitted time intervals will be important – practice may evolve to more frequent, but shorter, contacts with clients – has increased engagement
- Request for State to be deliberate in moving toward uniformity in regulations across MA agencies

FINGER LAKES RPC

9/11/20 Board Meeting

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Key Takeaways:

- While the telephonic mode is extremely valuable, there are some clients and circumstances in which it is not always the best modality:
  - New Clients, in some cases
  - Some Youth
  - Clients with Substance Abuse disorders
  - Assessments of Risk for Harm
  - Situations where abuse is a concern - child, family, or partner
  - Presentations where visual observation is needed or preferable

FINGER LAKES RPC

9/11/20 Board Meeting

Future of Telehealth Workgroup - MM

Identified, Discussed, and Ranked Key Factors in Telehealth

Survey Results - Highest Ranked TH Factors

(ranked for Importance and Regional Work Viability)

- Client Satisfaction
- Retention of Telephonic Modality
- Development of Clinical Guidelines
  - Indications
  - Contraindications
  - Best Practices
- Workforce Ramifications
- Rates, Permitted Time Intervals & Frequency of Visits

FINGER LAKES RPC

9/11/20 Board Meeting

Future of Telehealth Workgroup - MM

Identified, Discussed, and Ranked Key Factors in Telehealth

After Rankings and Discussion – Referral made to Clinical Integration & Practice Workgroup for:

Development of Telehealth Clinical Guidelines

Indications, Contraindications, Best Practices

Permitted Time Intervals & Frequency of Visits (w/Viable Rates)

FINGER LAKES RPC

9/11/20 Board Meeting

Future of Telehealth Workgroup - MM

Identified, Discussed, and Ranked Key Factors in Telehealth

Rochester Regional Health Telehealth Overview

- Mandy Teeter presented RRH's framework for reviewing and understanding the impact of the rapid transition to telehealth delivery of services.

- Very informative – see agenda for major takeaways. Full presentation attached to meeting materials.

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9/11/20 Board Meeting

Future of Telehealth Workgroup - MM

Identified, Discussed, and Ranked Key Factors in Telehealth

NEXT STEP

Convene Clinical Integration & Practice Workgroup

FINGER LAKES RPC

9/11/20 Board Meeting

BHCC Updates - Beth

- Integrity Partners Behavioral Health - BHCC
  Steve Harvey, President

- Finger Lakes and Southern Tier BHCC
  Lisa Smith, Interim Executive Director

FINGER LAKES RPC

9/11/20 Board Meeting

FLPPS – STACI Update - Beth

Nathan Franus, *Director*
System Transformation and Community Investment

System Transformation and Community Investment (STACI) Domain Summaries

Nathan Franus
Director of STACI

flpps Finger Lakes Performing Provider System

STACI Objectives

- Build upon the principles of DSRIP by using data-driven and transparent inputs to identify high-value and high-impact programs that support region-wide collaboration

- Continue and scale DSRIP "promising practices" across the following domains:
  - Behavioral health
  - Maternal and child health
  - Social Determinants of Health
  - Care Management

- Social Determinants of Health, Care Management, Telehealth, Workforce, and addressing health disparities will be considered throughout all domains

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STACI Guiding Principles

1. Target high risk populations and support the original DSRIP mission of reduction in cost of care, improvement in health outcomes and disparities and transition to VBP
2. Allocations across domains where data-driven, transparent inputs demonstrate an opportunity to impact DSRIP goals
3. Investments should demonstrate potential for sustainability of DSRIP work
4. Investments should foster collaboration and initiatives will be considered across networks of collaborating partners such as IPAs, BHCCs, and others
5. FLPPS will provide implementation support, project management, and/or analytics services to enable achievement of project goals and objectives

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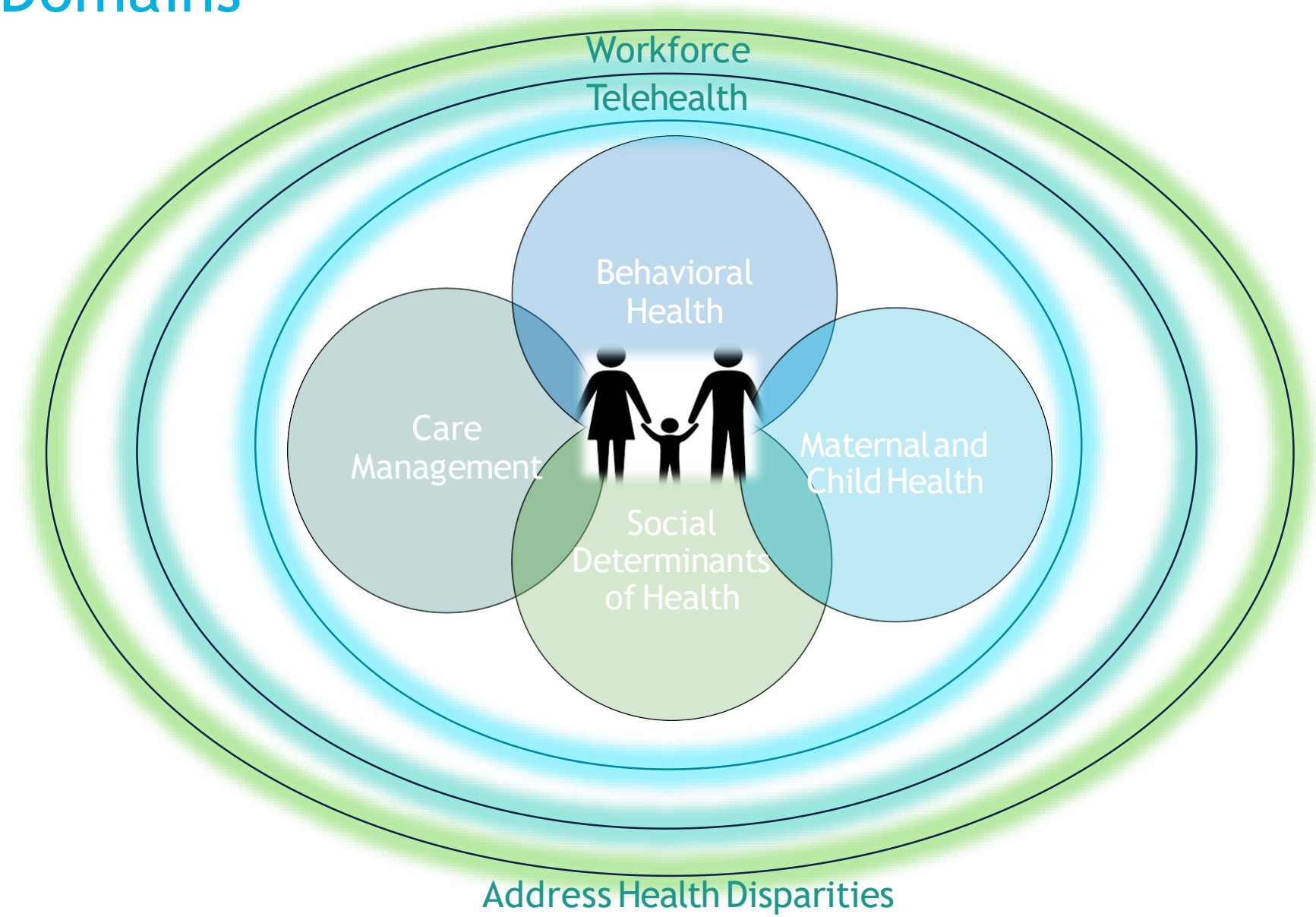
STACI Domains



Social Determinants of Health (SDH) Domain

Goals

- Improve quality & continuity of care for Medicaid patients in the FLPPS region by supporting social determinants of health connections and closed loop referrals

Objectives

- Support high need patients
- Identify SDH factors in performance, with a particular focus on those that result in health disparities
- Support advancing health equity by working with sectors on the SDH factors that influence health
- Align with community initiatives
- Be responsive to social service needs as a result of the current pandemic

Program Strategy

- Ensure geographically appropriate access to high functioning SDH providers (SDH service mapping)
- Build upon care navigation and care management programs
- Focus on new evidence based SDH interventions and scaling promising practices

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Maternal and Child Health Domain

Goals

- Improve the health and well-being of women, infants, children, and families

Objectives

- Provide care to address a wide range of conditions, health behaviors, and indicators that affect the health, wellness, and quality of life of women, infants, children, and families
- Support development of maternity and pediatric bundled payment arrangements with NYS DOH and regional maternal/pediatric providers

Program Strategy

- Build on and scale previous successful DSRIP interventions (i.e. CHW program)
- Develop interventions to reduce rate of low-birth weight babies in Monroe and other disparate counties
- Identify and address racial health disparities

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Behavioral HealthDomain

Goals

- Improve behavioral health outcomes in the FLPPS region within the Medicaid population and prepare networks and providers for VBP

Objectives

- Engage and support BHCC partner networks and individual providers in building program capacity, connections to primary care, and implementation of quality improvementinitiatives

Program Strategy

- Primary care access, BH service mapping and workflow design
- Coordination with County mental health departments
- Crisis program development, Medicated Assisted Treatment
- Interventions to address health disparities
- Peer support models in care continuum settings
- Workforce development

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Care Management Domain

Goals

- Improve population health and reduce avoidable ED/Inpatient visits for high-needs population
- Develop an approach to appropriately scale care management in response to patient level of need (PCMH, Navigation, HH etc.)

Objectives

- Use data to design sustainable models of care management
- Support technology solutions that improve care management workflows and support population health
- Deploy and support programmatic interventions that address the needs of individuals who are identified as high risk/high need

Program Strategy

- Use data to monitor impact on quality health outcomes
- Capacity building and/or right-sizing to ensure that services exist where there are hot-spots or high utilizer populations
- Clinical and non-clinical integration to address patients who need community based social support
- Workforce; include training, credentialing and retention
- Customize outreach to address race and ethnicity

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STACI Needs Assessment and Prioritization Methodology

- Per our Guiding Principles, FLPPS is leveraging our existing data on the Medicaid population in our region, examining performance on outcomes, and using this data driven and transparent approach to directionally inform our investment decisions.
- Analytic insights are a key input into each Domain's Needs Assessment, which will focus on recent and historical performance of Domain-specific outcomes within each FLPPS region.

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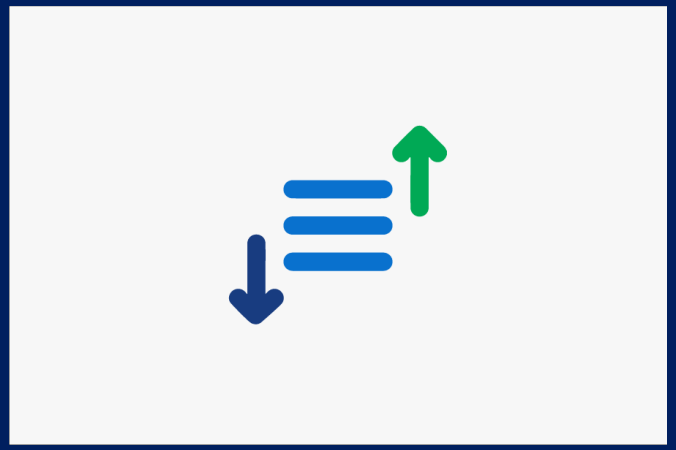
STACI Needs Assessment and Prioritization Process



- Needs Assessments have or will be presented to the FLPPS Clinical Quality Committee by Domain through the end of 2020.
- FLPPS Domain Leads will work in parallel with SMEs to identify and develop high-value and high-impact initiatives and interventions
  - Reference needs assessment analysis and obtain additional input/feedback to identify greatest areas of need and consider impact of COVID-19
  - Review historical DSRIP programs and identify promising practices
  - Prioritize initiatives and interventions
    - Identify SDOH and training needs
    - Evaluate opportunities to further leverage telehealth to increase access

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Finger Lakes Performing
Provider System

FINGER LAKES RPC

9/11/20 Board Meeting

RPC ACTIVITIES THIS QUARTER

Regional Planning Consortium

QUARTER TWO UPDATE

APRIL 1 – JUNE 30, 2020

NYS Conference of Local Mental Hygiene Directors, Inc.

RPC Pandemic Response

As COVID-19 began sweeping the globe and the focus of all communities shifted to adjusting to the demands of the pandemic, the RPC team remained dedicated to solving problems regionally to best assist our stakeholders during this unprecedented time. Although many of the issues established in Q1 by region may have "paused" with the rest of NYS, several new projects were completed and initiatives established during Q2:

- **Mental Health Access Survey:** derived from an OMH website listing of provider organizations, 343 programs were identified; 311 were telephonically contacted, providing specific information regarding their ability to provide intra-muscular (IM) injections, and an estimate of the percentage of their services being provided by telemental health.
- **Behavioral Health Crisis Resource Guide**: RPC Regional staff created comprehensive and timely listings of county, regional, state, and national resources for stakeholders into a consolidated directory for ease of access during a challenging time.
- **RPC Service support to OMH for COVID-19 response activities** from April 23, 2020 through June 22, 2020.
  - Personal Protective Equipment (PPE) survey development and data analysis to assist OMH with collecting regionally specific information related to PPE and Office of Emergency Management (OEM).

RPC Pandemic Response

COVID-19 Telemental Health Tracker - The RPCs catalogued remarks related to telehealth during the COVID-19 State of Emergency from March 12 through June 5. The information collected during this timeframe will be used to inform dialogue during the October 29, 2020 Virtual State/Co-Chairs Meeting. In addition to access, topics will include service delivery, workforce, telehealth sustainability, revenue cycle management during/post COVID-19, and client experience and feedback.

ACCESS DEFINITION

Ability to access services, including challenges to access, timely ability to schedule and receive services.

TOP ACCESS REMARKS (by Frequency)

Access Remarks by Population (n=18)

TOP ACCESS REMARKS

In 5 Regions (Adult & Child Population): Providers are partnering with their counties and other providers (i.e. Unitedway) to utilize funds and purchase more phones and minutes for clients as many still do not have working phones

In 5 Regions (Adult Population): Telehealth option has increased ability to get needed assessments done for HCBS eligibility quicker and easier as many barriers eliminated.

In 9 Regions (Administrative):Seeing a decrease in cancelled/no-show appointments through telemental health. Clients are more consistently engaging in services with the telehealth option. A hybrid of being able to do in-person, but use telehealth when needed would be beneficial

In 10 Regions (Adult & Child Population): Telehealth has eliminated some transportation issues for clients. Able to engage in more services with this barrier being eliminated. Also decrease appointment cancellations for transportation issues.

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2020 RPC Areas of Focus

Behavioral Health Workforce

- Central New York RPC concluded pilot with Syracuse University on Care Coordination Certificate Program
- Collaboration with Office of Consumer Affairs on how to best engage Peer, Family, Youth Advocates in the RPC with future collaborations planned
- Establishment of Statewide Peer/Family/Youth Stakeholder meetings and appointment of Group Leads
  - Kirsten Vincent, Western Region Co-Chair and Amanda Pierro, Capital Region Co-Chair

Children & Families

- CFTSS and HCBS Capacity Survey gaining traction across regions with Mid-Hudson joining Long Island and Mohawk Valley in data collection
- Collaboration with Interagency Technical Assistance Team (OASAS, OMH, OPWDD, OCFS) on the technical assistance needs of providers related to the children's transition
- Reestablishment of the Statewide Children and Families Co-Lead Meeting to ensure continuity of voice and focused collaborative initiatives across all regions – to be launched in July 2020.

Innovations in Value Based Care

- Planning for Inaugural "RPC Managed Care Roundtable" meeting in July 2020

Social Determinants of Health

- Examining statewide strategies for Co-Occurring Systems of Care, Transitions in Care for homeless adults with recent psychiatric admissions, and housing options for the behavioral health population

2020 RPC Areas of Focus

In Q2, from a statewide perspective, the RPC continued to develop our four Areas of Focus in 2020. In cooperation with the impactful work occurring within our Boards across the state, common statewide drivers continue to evolve and the RPC has established formalized, agile Project Concentration Cohort teams to carry our collective voice. These teams will work to ensure subject matter expertise, communications and issues are consistently shared across settings to include agency partners within our four domains:

VBP/ Managed Care: Primary Care Integration	LORI KICINSKI	BETH SOLAR	BETH WHITE
SDOH/ Care Transitions and Co-Occurring Integration	MARCIE COLON	COLLEEN RUSSO	KAREN RAPPLEYEA
Behavioral Health Workforce	KATIE MOLANARE	EMILY CHILDRESS	TIFFANY MOORE
Children and Families	JACQUELINE MILLER	ALYSSA GLEASON	KATERINA GAYLORD

For further information about the Regional Planning Consortium, please contact:

RPC Project Director: Lori Kicinski, (518) 867-1159

RPC Assistant Project Director: Katerina Gaylord, (518) 396-0788

Finger Lakes

DCS Co-chair: Margaret Morse, LMSW, Seneca County

Community Co-chair: Ellen Hey, MS, FNPC, Chief of Quality, Finger Lakes Community Health

RPC Coordinator: Beth White

Board Membership: Finger Lakes RPC Board Members

Click HERE to visit the Finger Lakes RPC web page

Meetings Held During Quarter 2

- CFTSS/HCBS Sustainability Learning Collaborative – 4/13, 5/4, 5/21, 5/27
- Finger Lakes RPC Board – 5/15
- Overview of "820 Setting – Continuation of Managed Care Coverage" – 6/15
- Future of Telehealth Workgroup – 6/19
- Hospital System Meeting re PA Practice in MH Clinics – 6/25
- Physician Assistant Program at Rochester Institute of Technology (RIT) – 6/25

Q2 Top 3 Issues: Identification & Issue Development/Due Diligence

- Physician Assistant (PA) Scope of Practice in Article 31 Clinics – cannot assess or prescribe without completion of OMH waiver process, resulting in an important workforce resource unable to fully deliver critically needed services to clients
- Children & Families providers report CFTSS/HCBS services not financially sustainable
- Residents of 820 OASAS housing programs are losing Managed Care insurance due to a processing problem at LDSS around the Congregate Care Level 2 application.

Click HERE to return to Table of Contents

Finger Lakes continued

Next Steps

- Confirm Status of new Physician Assistant Psychiatry Track Curriculum at RIT which may result in PA's being permitted to prescribe in Article 31 Clinic without needing the currently required OMH waiver process
- Convene closing session of CFTSS/HCBS Sustainability Learning Collaborative
- Survey Learning Collaborative participants on the value of the learning tool & the Collaborative experience
- Follow-up with regional 820 OASAS providers to gauge success of the implementation of the formal GIS notice intended to correct the interruption of clients' Managed Care coverage

Achievements & Upcoming

- Finger Lakes Crisis Resource Guide issued – Apr 29
- Convened First Meeting of New Finger Lakes RPC Workgroup – Future of Telehealth
- As a direct result of the work of the WNY RPC, with advisement and support from the Finger Lakes RPC, NYS DOH, OTDA and OASAS jointly issued a formal GIS notice to Local DSS Commissioners correcting the interruption of clients' Managed Care coverage when they are admitted to OASAS 820 settings.

FINGER LAKES RPC

9/11/20 Board Meeting

RPC Activities this Quarter - Beth

Children & Families Subcommittee – met August 3 – 53 Attendees

Children starting to tire of TH visits

Exhausting for staff to do 8 hrs/day TH visits

Concerns about not being able to be on-site in schools in fall

Still much confusion about how to use OLP services and the difference between a referral and a recommendation, need for more education and outreach to community allied health providers

CFTSS/HCBS Sustainability Learning Collaborative almost wrapped up

Bed Finder Migration to North Country/Tug Hill continues

FINGER LAKES RPC

9/11/20 Board Meeting

NEXT MEETING

FRIDAY, November 13

1-3:00pm - virtual

FINGER LAKES RPC

9/11/20 Board Meeting

ADJOURNMENT

Margaret

THANK YOU!

28 BOD
4 guests
1 mai

33

FINGER LAKES REGIONAL PLANNING CONSORTIUM - BOARD OF DIRECTORS MEETING
BOARD MEMBERS ROLL CALL - SEPT 11, 2020

Group	Name	Sign In	Group	Name	Sign In
LGU	Margaret Morse	✓			
LGU	George Roets	✓	MCO	Colleen Klintworth	✓
LGU	Shawn Rosno	✓	MCO	Angela Vidile	✓
LGU	Michele Anuszkwiecz	✓	MCO	Jennifer Earl	✓
LGU	Diane Johnston	—	MCO	Ivette Morales	✓
LGU	Kelly Wilmot	✓	MCO	Claire Isaacson	—
CBO	Sally Partner	✓	EX OFFICIO	Christina Smith	—
CBO	Val Way	✓	EX OFFICIO	Christopher Marcello	✓
CBO	Jennifer Carlson	✓	EX OFFICIO	Colleen Mance	—
CBO	Ann Domingas	—	EX OFFICIO	Kathy Muller	—
CBO	Lori VanAuken	✓	EX OFFICIO	JoAnn Fratarcangelo	—
CBO	Lindsay Gozz-Theobald	✓			
			KEY PARTNER	Melissa Wendland	✓
Peer	Jennifer Storch	—	KEY PARTNER	Nathan Franus	✓
Peer	Jeannine Struble	✓	KEY PARTNER	Christopher Bell	✓
Family	Julie Vincent	✓	KEY PARTNER	Denise DiNoto	✓
Family	Jeffrey Hoffman	✓	KEY PARTNER	Lisa Stauch Smith	✓
Youth	Rita Cronise	✓	KEY PARTNER	Steve Harvey	✓
Youth	OPEN				
			OTHERS?	Katerina Gaylord	
HHSP	Ellen Hey	✓		Tiffany Morse	
HHSP	George Nasra	—		Beth Solar	
HHSP	Mandy Teeter	✓		Karen Rappleyea	
HHSP	Mary Vosburgh	—		Mai - Beth White	
HHSP	Craig Johnson	✓			
HHSP	OPEN				

FINGER LAKES REGIONAL PLANNING CONSORTIUM

Board of Directors – September 2020

RPC CoChair: Margaret Morse **RPC CoChair:** Ellen Hey **RPC Coordinator:** Beth White

Community Based Organizations

Mental Health: Sally Partner, VP of Strategic Growth and Advocacy, Catholic Family Center

Substance Use Disorders: Jennifer Carlson, CEO, FLACRA

Children's Services: Lindsay Gozzi–Theobald, Chief Program Officer, Villa of Hope

Housing: Valerie Way, Vice President of Programs, East House

HCBS: Lori VanAuken, Executive Director, Catholic Charities Community Services

Rural Provider: Ann Domingos, CEO, CASA-Trinity

Hospital and Health System Providers

Hospital: Mandy Teeter, Vice President of Behavioral Health, Rochester Regional Health

Hospital: George Nasra, Psychiatrist, Division Chief, University of Rochester Medical Center

Hospital: Mary Vosburgh, Vice President of Nursing, Arnot Health

FQHC: Ellen Hey, Chief of Quality, Finger Lakes Community Health, Board CoChair

FQHC: Open

Health Home Lead Agency: Craig Johnson, COO, Huther Doyle Memorial institute

Peers, Family and Youth Advocates

Peer: Jennifer Storch

Peer: Rita Cronise

Youth Advocate: Julie Vincent

Family Advocate: Jeannine Struble

Family Advocate: Jeffrey Hoffman

Youth Advocate: OPEN

Managed Care Organizations/HARP's

Excellus Health Plan: Colleen Klintworth, Behavioral Health Gov't & Community Affairs Manager

Fidelis Health Care: Ivette Morales, Clinical Program Development Manager

Molina Healthcare: Claire Isaacson, Manager, HARP/HCBS Case Management

MVP Health Care: Angela Vidile, Director, Behavioral Health

United Healthcare Community Plan: Jennifer Earl, Government Liaison

Directors of Community Services - LGU's

Livingston County: Michele Anuszkiewicz

Monroe County: Kelly Wilmot

Ontario County: Diane Johnston

Schuyler County: Shawn Rosno

Seneca County: Margaret Morse, Board CoChair

Yates County: George Roets

Key Partners

Common Ground Health: Melissa Wendland, Director of Strategic Initiatives

Finger Lakes and Southern Tier BHCC: Lisa Stauch Smith, Interim Executive Director

Finger Lakes PPS: Nathan Franus, Director - System Transformation and Community Investment

Integrity Partners for Behavioral Health: Steven Harvey, CEO

Monroe County Medical Society: Christopher Bell, Executive Director

Rochester RHIO: Denise DiNoto, Director of Community Services

Ex Officio

OMH Western Field Office: Christina Smith, Director & Chris Marcello, Deputy Director

OASAS Field Office: Colleen Mance, Program Manager

LDSS: JoAnn Fratarcangelo, Schuyler County Commissioner of Social Services

LDSS: Kathryn Muller, Steuben County Commissioner of Social Services

Jordan Health

Representative to Board: Laurie Donohue, Chief Medical Officer

LOCATED IN: Rochester and Canandaigua, NY

Services Delivered: Our network of 9 comprehensive health centers and primary care offices provides affordable and accessible healthcare for nearly 30,000 patients in the cities of Rochester and Canandaigua, New York.

The health services that became the Anthony L. Jordan Health Center, began more than 100 years ago, in 1904, and was one of the first five Federally Qualified Health Centers (FQHC) established in the nation. Located in neighborhoods where the most pressing need exists, Jordan's roots are steeped in service to underserved and uninsured residents, meeting their need for comprehensive health services. Anthony L. Jordan Health Center began in northeast Rochester and has since expanded to become a network of primary care offices and health centers serving residents of Rochester and Canandaigua, N.Y.

Jordan Health is an independent FQHC, with Level III Patient-Centered Medical Home (PCMH) designation through the National Committee on Quality Assurance. While independent, Jordan Health actively collaborates with the major hospital and healthcare systems in our operating area to provide a total safety net of healthcare services.

Counties Served: Monroe, Ontario

Voice Vote on Jordan Health Nomination as Key Partner 9/11/20

FINGER LAKES REGIONAL PLANNING CONSORTIUM - BOARD OF DIRECTORS MEETING
BOARD MEMBERS ROLL CALL - SEPT 11, 2020

Group	Name	Sign In	Group	Name	Sign In
LGU	Margaret Morse	Y			
LGU	George Roets	Second Y	MCO	Colleen Klintworth	Y
LGU	Shawn Rosno	Y	MCO	Angela Vidile	Y
LGU	Michele Anuszkwiecz	Y	MCO	Jennifer Earl	~~no ans~~ Y
LGU	Diane Johnston		MCO	Ivette Morales	Y
LGU	Kelly Wilmot	no ans	MCO	Claire Isaacson	
CBO	Sally Partner	Y	EX OFFICIO	Christina Smith	
CBO	Val Way	Y	EX OFFICIO	Christopher Marcello	
CBO	Jennifer Carlson	Y	EX OFFICIO	Colleen Mance	
CBO	Ann Domingas		EX OFFICIO	Kathy Muller	
CBO	Lori VanAuken	Y	EX OFFICIO	JoAnn Fratarcangelo	
CBO	Lindsay Gozz-Theobald	Y			
			KEY PARTNER	Melissa Wendland	moved
Peer	Jennifer Storch		KEY PARTNER	Nathan Franus	
Peer	Jeannine Struble	Y	KEY PARTNER	Christopher Bell	
Family	Julie Vincent	Y	KEY PARTNER	Denise DiNoto	
Family	Jeffrey Hoffman	Y	KEY PARTNER	Lisa Stauch Smith	
Youth	Rita Cronise	Y	KEY PARTNER	Steve Harvey	
Youth	OPEN				
			OTHERS?		
HHSP	Ellen Hey	Y			
HHSP	George Nasra				
HHSP	Mandy Teeter	Y			
HHSP	Mary Vosburgh				
HHSP	Craig Johnson	Y			
HHSP	OPEN				

CLMHD Regional Planning Consortium

RPC - FINGER LAKES REGION
Chemung Livingston Monroe Ontario Schuyler Seneca Steuben Wayne Yates

FINGER LAKES REGIONAL PLANNING CONSORTIUM

Board of Directors

MINUTES

May 15, 2020 1pm-3:00pm
Gotomeeting Conference Call

- Margaret Morse called the meeting to order at 1:01 PM.

- **Roll Call & Confirm Quorum** – Beth confirmed Quorum to meet is present, but Quorum for voting not present at the start of the meeting.

- **Approve March 13th Minutes –** Motion to approve made by George Roets. Seconded by Jennifer Earl. No discussion. All were in favor, none opposed. Minutes approved.

- **Finger Lakes RPC Board Elections Update –** BHCC's – Survey Monkey results showed unanimous approval by the Board to include BHCC's on the Board. Majority voted to have them join as Key Partners. All three BHCC's are interested in joining. There were no comments or discussion on this.
    - **Lisa Smith –** Finger Lakes and Southern Tier BHCC (on call)
    - **Steve Harvey –** Integrity Partners
    - **Maureen Bischoff –** discussing who will represent Your Health Partners of the Finger Lakes

- **Proposed By-Law Amendments** (attached) – Beth gave background on proposed changes.

    - To allow voting quorum to be suspended for purpose of approving minutes
    - To recognize and permit electronic voting

    No voting Quorum present on call, so unable to vote on this at this time. Will move to the next meeting for a vote.

- **RPC Activities –** Beth reviewed all RPC activities from the last meeting. Activities include Crisis Resource Guide, Mental Health Access Survey (attached to email with agenda), C&F CFTSS/HCBS Sustainability Learning Collaborative, Bed Finder, PA Scope of Practice.
    - **CFTSS/HCBS Sustainability Learning Collaborative** – is underway and has 6 providers who are participating. It's an educational tool that allows the providers to look at different scenarios to assist with staffing and maintain fiscal sustainability.

- **Bed Finder** – capturing and compiling data. North Country and Tug Hill region are adding it. On hold with CR's as when they spoke with the programs directly they weren't sure it would be worth the work. Valerie Way stated she would be willing to help with trying to get them on board as it would be good for them to be a part of it.
- **PA scope of Practice** – proposal to OMH is being put together
- **Workgroups/Events** – C&F is focused on the Learning Collaborative. No workgroup meetings presently scheduled, but work is still occurring. Asked for feedback re if workgroup meetings would be helpful or not right now, given what everyone is dealing with due to COVID. One reply was that there are a lot of meetings at this time, so another meeting may be a lot.

- Beth updated Board on the modified contract with OMH to assist during the State of Emergency. Work will most likely focus on information and data gathering.

- **Future of Telemental Health** - Margaret lead discussion on what issues have been learned and opportunities that have come from the move to telehealth. What should the State know about telehealth?
  - **Mary Vosburgh** – will type up comments as unable to hear her through the audio.
  - **Lori Van Auken** – seen increased efficiency, reduction in mileage. Telehealth shouldn't be the be end all and be all. A combination of in-person and telehealth can be cost savings and beneficial for some clients.
  - **Valerie Way** – clients are saying that they appreciate telehealth and feel more connected to their therapist. No show rates have dramatically decreased. Those who were more difficult to engage are engaging now through telehealth. Telehealth has been extremely helpful in care coordination processes.
  - **Jennifer Carlson** – echoes Lori and Valerie. Telehealth helps with those in remote areas. Beneficial to clients depending upon the intensity of the services they need.
  - **Craig Johnson** – Health Home doing well. SUD clinic doing well and finding ways to get people in for injectables. Concern is for the waiver ending and those not previously allowed to perform telehealth (non-licensed) as this is 70% of their staffing. This will pose a challenge.
  - **Brian Hart** – telehealth is a nice option, but need to make sure it is not a cost to the consumer as this will be an issue (Ex: paying for the platform). Others stated that the platform set up would be on the agencies and not consumers, but things like data and minutes could be a cost to the consumer.
  - **Margaret** – telephonic sessions have been effective for those without Wi-Fi or the technology to do audio/visual sessions. Some clients are doing better on the phone than they did in-person.
  - **Melissa Wendland** – are people collecting data to help with advocacy?
  - **Chris** – OMH – survey from Office of Consumer Affairs received 3,700 responses in one week. There is a plan for more formal surveying to help with the regulatory planning.
  - **Valerie** – there are a lot of surveys from different providers. Encourages survey consolidation and share the data between organizations/agencies. Staff working from home has allowed for flexibility and has been advantageous.
  - **Jennifer** – using professional licenses more productively as travel is eliminated.

- **Brian Hart** – concern regarding lower rates for telehealth. They had received notification from Blue Cross at the beginning that there would be a 5-10% decrease in rates for billing with GT or 95 modifier.
- Others responded that for the State of Emergency, everyone should be receiving the standard rates. Agencies have not seen any MCO's doing this during the State of Emergency. They are being paid at the normal rate.
- Discussion regarding rates for telehealth vs. face to face. Many felt that the service is the service. Advocacy is needed around this as there shouldn't be a different rate for services through telehealth. Telehealth has wound up being a better modality for some clients. Seen an increase in show rates since moving to telehealth. There are benefits and advocacy is needed.

- **Stakeholder Group Report** – Beth lead discussion for each stakeholder to report on how they are doing and how the RPC could help.
  - **Peer Group**: Rita Cronise – continuing work with toolkit and working on forming a learning collaboration. There are a lot of online supports. Peers are finding that clients are feeling like it is hard to connect with others through technology.
  - **Hospital/Health System:** Mandy Teeter – most critical issue is lull in referrals for inpatient (psychiatric and SUD). Starting to see an increase. They know there is a need for these beds. Moving forward as reopen they are concerned with social distancing for inpatient. Seeing outpatient referrals increase. Outpatient no show rate is normally high, but lower with telehealth. Walk-ins were big and they are still trying to figure out how to do a "virtual walk-in".
  - **CBO's:** Sally Partner – doing some walk-ins with quick conversion to telehealth. It's affected different programs in different ways, but they are all making it work.
  - **MCO's:** Focus on claims going through and staying on top of guidance. Open and able to help providers. This time is challenging, but invigorating. Provider Relation teams have been proactive and are hosting webinars. They aren't hearing a lot of challenges. They have seen an 8000% increase in telehealth (medical and behavioral health) comparing last year to this year
  - **DCS's:** George – from a small rural city perspective. Programs/Services are interdependent and we know where skills lie, so able to make connections. This crisis has exacerbated issues that already existed, ex: public transportation. Seen an increase in homelessness, connectivity issues, and people struggling to find housing. Need to prepare to "fight" for continuing telehealth/medicine by getting data and being proactive.
    Margaret – echoes George. Recent statistics on food insecurity show that 20% of children don't have enough food. Doing county food drives. Crisis exacerbated pre-existing issues for marginalized populations.
  - **Key Partners:** Melissa Wendland – asked about insight in to CMS waivers regarding reintegration.
    - **Colleen OASAS –** attestation for SUD are being honored until September 7th
    - **Chris OMH –** regulatory relief group was formed. Mapping out what they need to request extensions on. They are working to align all of the executive orders as they all expire at different times. Need to also focus on substantiating the anecdotal information. For example, need data on no show rate pre-COVID and during the State of Emergency. Need

client feedback regarding services. RPC could assist with provider surveys. What is the experience for those in inpatient?

- **Nathan Franus –** DOH proposed to CMS regarding the 115 Waiver – they asked for funding to stabilize agencies which would cover March 2020 through March 2021. Look at redeploying PPS to scale up practices during the pandemic.

- **By-Laws Motions Revisited** – Beth pointed out that there is now a voting quorum as others have joined the call. Margaret read each motion.

Motion #1: To authorize the suspension of the Finger Lakes RPC Board's Voting Quorum requirement in order to approve prior Board meeting minutes

If motion passes, then the following language will be added to the Finger Lakes RPC Bylaws on pg. 5 under "Board Meeting Quorum:"

Should a Board meeting occur without the presence of a sufficient number of members to constitute a Voting Quorum, the presiding CoChair, or Coordinator in their absence, is authorized to request a motion to suspend the Voting Quorum requirement for the purpose of approving the prior meeting's minutes. If the motion is seconded and then approved by a simple majority of the voting members in attendance, the process for approving minutes can proceed for that meeting.

- George Roets moved to approve
- Sally Partner seconded the motion
- None opposed
- Amendment passed

Motion #2: To Acknowledge and Authorize Electronic Voting

If motion passes, then the following language will be added to the Finger lakes RPC Bylaws on pg. 3 under "Role and Responsibilities" under "Voting Stakeholders:"

After " Actively participate in Board meetings," insert new line:

"In instances where the Board meeting has occurred through a virtual meeting or when a vote is held outside of a Board meeting, respond promptly to electronic voting requests. This provision does not authorize electronic voting for members not in attendance at in person meetings."

- Colleen Klintworth moved to approve
- Jennifer Earl seconded the motion
- None opposed
- Amendment passed

- **New Workgroup** – Consensus reached to establish a new workgroup for information and data gathering to assist with the telehealth advocacy moving forward. Parties interested: Margaret, Jennifer, Craig, and Mandy Teeter. Beth will send a survey after the meeting to assess any other interest.

There being no objection, Margaret declared the Meeting Adjourned at 2:41 PM.

Regional Planning Consortiums

Finger Lakes Region Bylaws

Article I: Purpose

To serve the transformation of the Medicaid behavioral health system the creation of the NYS Regional Planning Consortiums (RPC) were authorized through the Centers for Medicare and Medicaid Services (CMS) 1115 waiver. The RPC is where collaboration, problem solving and system improvements for the integration of mental health, addiction treatment services and physical healthcare can occur in a way that is data informed, person and family centered, and cost effective. *Our goal is to improve the overall health for adults and children in our communities.*

Purpose of the RPC Boards

The function of the RPC is to collaborate, analyze and problem solve issues that arise in the managed Medicaid behavioral health system. The Board identifies, researches, and prioritizes issues, determining viability and actionable steps for regional resolution as well as recommendations and ideas for state partners.

Article II: Membership of the RPC Regional Boards

The Board of Directors of the Finger Lakes RPC shall be comprised of members as prescribed by the NYS Regional Planning Consortium initiative's definition of stakeholder groups and shall follow its directives regarding election of members for said groups.

The RPC Membership is comprised of seven stakeholder types, with both voting and non-voting Board members:

The voting stakeholder groups are:

- **Community Based Organizations (CBO)** – comprised of representatives from the following organization types: Mental Health, Substance Use Disorder, Children's Services, Adult Behavioral Health HCBS Providers, Housing Providers. Some regions have a rural organization from any of the organizations represented on their Board as well. Regions may choose to designate the sixth (6^{th}) seat as a rural or other designation as deemed appropriate by the region. Any organization providing Medicaid billable services and are licensed or designated by either OMH or OASAS are eligible for election to one of these seats.
- **Hospital and Health System Providers (HHSP)** – comprised of two representatives from each organization types: Hospitals and/or Health System Providers, Federally Qualified Health Centers and Lead Health Homes (Adult and/or Children). If there is insufficient interest from an organization type the Board may choose to have an additional representation from another organization type within this stakeholder group.

- **Peer/Family/Youth Advocates (PFY)** –comprised of two peer representatives, two family members, and two youth advocate members. Members of this stakeholder group may work for an agency that provides behavioral health services but, in their Board member role, they are asked, when possible, to represent their personal experience as a peer or family member rather than their employer's agency perspective. If there is insufficient interest from a member type the Board may choose to have an additional representation from another member type within this stakeholder group.
- **Medicaid Managed Care Organizations (MCO's)** – each MCO organization has a contractual obligation to appoint a staff member to represent their organization.
- **County Directors of Community Services (DCS's)** – each RPC region will select up to six (6) members (if available) to serve on the RPC Board.

The non-voting stakeholder groups are:

- **Key Partners** – Various members elected by the Board due to their related subject matter expertise. For example, members who represent regional PHIP, PPS, LDSS or LHD.
- **Ex Officio** – Members eligible due to their related roles, i.e. State Partners and BHO's
- **Regional Need** – The Finger Lakes RPC Board may elect to move specific Key Partner seats, i.e. LDSS, LHD or PPS to Ex Officio status in order to include additional Key Partners on the Board

CoChairs

Each RPC Board will be facilitated and lead by two RPC CoChairs. One CoChair is a Director of Community Services (DCS) and selected by the regional DCSs. The other CoChair is selected from one of the following stakeholder groups:

- Community Based Organizations
- Managed Care Organizations
- Peer/Family/Youth Advocates
- Hospital & Health System Providers

The non-DCS CoChair is self-nominated and elected by voting Board members.

CoChair role and responsibilities:

Leadership:

- Manage and provide overall leadership to the Board, identifying goals, strategy that advocates regional goals.
- Represent the region at RPC activities and meetings.
- Lead effective and efficient Board meetings, promote effective relationships, open and inclusive communication in meetings and internally mediate contentious relationships.
- Create a culture that allows constructive dialogue, including challenges and varying opinions and consensus decision-making.
- Ensure the Board as a whole is engaged in the identification and development of issues and determination of Board decisions, recommendations, and ideas.
- Serve as an ambassador of the RPC, advocating its mission to internal and external stakeholders

Logistics:

- In person attendance at regional Board meetings and state partner meetings.
- On-going collaboration with their CoChair counterpart and RPC Coordinator.
- Develop/organize in concert with CoChair and RPC coordinator the Board's meeting agenda.
- Attend and participate in the RPC CoChairs calls and complete requested surveys.

- Serve as an access point for members of the community who have questions or would like to bring issues to the attention of the RPC
- Enact and uphold the Finger Lakes bylaws

Voting Stakeholders

The RPC Boards each consist of five voting stakeholder parties:

- Community Based Organizations
- Hospital/Health System Providers
- Peers/Family/Youth Advocate's
- Director of Community Services
- Managed Care Organizations

Role and responsibilities:

- Attend quarterly RPC Board Meeting in person, no proxy or call in option is available
- Review Board meeting minutes, to be voted on for approval
- Review meeting agenda and materials prior to each Board meeting
- Represent the collective views of the RPC Board and your stakeholder group in your region
- Identify, prioritize, and sort the recommendations/ideas/solutions that have been identified by the region.
- Serve as an access point for members of the community who have questions or would like to bring issues to the attention of the RPC
- Actively participate in Board meetings
- Participate in workgroup/subcommittee levels or encourage that a staff member from your agency participate when appropriate.
- Deliberate and vote on regional solutions and priority recommendations/ideas to be forwarded to our state partners.

Non-voting Stakeholders

The RPC Boards consist of two non-voting stakeholder parties, they include:

- Key Partners (represent various community organization, including but not limited to PHIPs, PPSs, LDSS, LHD)
- Ex Officio Members
    - State Agencies Representatives (From OMH, OASAS and OCFS)
    - BHOs

Role and responsibilities:

- Attend quarterly RPC Board Meetings in person, and will not send a proxy to the meeting
- Review meeting minutes prior to Board meetings
- Review meeting agenda and materials ahead of each Board meeting
- Represent the collective views of the RPC Board and your stakeholder group in your region
- Actively participate during the Board meetings
- In instances where the Board meeting has occurred through a virtual meeting or when a vote is held outside of a Board meeting, respond promptly to electronic voting requests. This provision does not authorize electronic voting for members not in attendance at in person meetings.
- Present on the Board any updates from your represented agency
- Serve as a subject matter expert on the topical areas connected to your organization

- Participate in regional workgroups and/or subcommittee levels or encourage that a staff member from your agency to participate, when relevant.

RPC Coordinator

The RPC Coordinator collaborates with and supports the RPC CoChairs, Board members and regional work groups/subcommittees to develop, organize and document the action steps taken to address the recommendations/ideas/solutions identified by the region. RPC Coordinator is not a voting member of the Board and will maintain a neutral stance pertaining to the issues/concerns/recommendations and ideas identified at the Board level. They will serve as an advisor to the Board assisting with goals, approach, feasibility, and information.

Role and responsibilities:

- Collaborate with RPC CoChairs and subcommittee chairs to develop meeting agendas
- Arrange venue sites for ongoing Board meetings
- Prepare materials for Board meetings
- Update Board membership list as needed and will work with CLMHD communications director to update website with this information
- Document and review meeting minutes, send to Board members for their review
- Facilitate active participation in meetings, working to include all Board members and stakeholder viewpoints.
- Create living documents identifying regional concerns, actions, recommendations, resources, and ideas.
- Outreach community organizations as needed when the Board/workgroups expresses an interest in learning more about resources
- Collaborate with RPC Coordinators to align common themes, share best practices, resources intra-regionally
- Assist Board and workgroups in the identification, analysis, and development of issues.

Article III: RPC Code of Ethics

The RPC Board is an apolitical Board that represents the collective views of various stakeholders and as such will represent the collective voice of the region.

The members and staff of the RPC are committed to:

- being responsible, transparent, and accountable for all of our actions
- accountability and responsible stewardship of our financial and human resources
- avoiding conflicts of interest and removing themselves from meetings or activities that jeopardize the integrity of the RPC
- treating every individual with respect, fairness, and dignity
- being mindful of stigmatic language and references
- advocating for access to and quality of Medicaid Managed Care Services for recipients and not for any specific organization member or non-member needs.
- maintaining a neutral political stance when acting as part of the RPC
- ensuring vendors/key partners who present their subject matter expertise at RPC sponsored events do not use the forum for self-gain through marketing and sales. All vendors/key partners will be informed of this limitation prior to any RPC engagement.
- respecting and maintaining confidentiality regarding the organizational, personal, or proprietary information shared by other RPC members in the course of RPC business.

Article IV: RPC Board Member Elections and Terms

Length of Board member term and election structure:

CoChairs

- CoChair terms are for 3 years. CoChairs are eligible to serve a second term.
- DCS CoChairs will be selected by and from the DCS stakeholder group.
- Non-DCS CoChairs will be elected by their voting Board members according to the NYS RPC election guidelines.
- CoChairs may resign at any time by submitting written or emailed notice to the fellow CoChair or RPC Coordinator.
- CoChairs missing two out of the four most recently scheduled meetings shall have been determined to be not sufficiently available to serve in the role, the office deemed vacant and filled in accordance with established procedure.

Voting Board Members

- Board members will be elected by their community stakeholder members to a 3 year term according to the NYS RPC election guidelines.
- If a Board member decides not to serve a full term, the seat for that stakeholder position is considered open and the organization has 30 days to fill that position with another appropriate organization member. This process does not require another vote.
- If the agency does not respond within 30 days, then requests for nominations will be solicited and an election will be held for the open seat. Eligible voters are Board members of all voting stakeholder groups.
  Exception: Managed Care Organizations and DCS's are contractually obligated to participate in the RPC and are not bound by elections/terms but rather assigned by their respective organizations.
- Board members may resign at any time by submitting notice in writing to a CoChair.
- Board members missing two out of the four most recently scheduled required meetings shall have been determined to be not sufficiently available to participate productively in the RPC, and the seat deemed vacant and filled in accordance with established procedure.
    - CoChairs have the discretion to review the individual circumstances and determine next steps regarding removal or reprieve of Board members.

Article V: Meetings, Subcommittees and Work Groups

Board Meeting Quorum

- A quorum of 50% plus one of current voting Board members, including at least one member of each voting Stakeholder group, must be present.
- In order to vote, a quorum of at least 3 members of each voting Stakeholder group must be present.
- Should a Board meeting occur without the presence of a sufficient number of members to constitute a Voting Quorum, the presiding CoChair, or Coordinator in their absence, is authorized to request a motion to suspend the Voting Quorum requirement for the purpose of approving the prior meeting's minutes. If the motion is seconded and then approved by a simple majority of the voting members in attendance, the process for approving minutes can proceed for that meeting.

Meetings

RPC Boards:

- will meet each quarter per calendar year. Additional meetings may be scheduled as needed.
- are open to Public to observe; seats may be limited according to space limitations.
- may conduct their meetings according to their regional needs and preferences.

Subcommittees and Work Groups

- Subcommittees and workgroups are authorized by and accountable to the RPC Board
- The topics, terms, goals, and objectives of the workgroups are determined by the region and workgroup leadership and members.
- Workgroups must be led by either a member of the RPC Board or the RPC Coordinator.
- All RPCs will establish a Children and Families Subcommittee to meet a minimum of 4 times per year effective Q3 2018.

Article VI: Collaborative Governance

COLLABORATIVE GOVERNANCE WITH CONSENSUS DECISION MAKING

The governance structure and consensus decision making process will use the collaborative governance model which is built on the following foundation.

Collaborative Governance

Perhaps the most notable success of collaborative governance with consensus decision making is the National Quality Forum (NQF), which brings together working groups from the public and private sectors to endorse consensus standards for healthcare performance measurement which are evidence-based and valid. The result is high-quality performance information that is publicly available and recognized as the gold-standard for healthcare quality.

Collaborative governance creates the structure and rules under which the RPC will function and carry out its mission. ***The consensus decision making process is critical because if the group is engaging in collaborative problem solving, the need to invoke a formal vote is minimal if not eliminated. The operative word is collaboration.***

There are several critical factors for successful collaboration and consensus building:

1. *Face to face dialogue*
2. *Trust building*
3. *Development and commitment to shared understanding of the interests of other parties*
4. *Shared goals*
5. *Leadership*

Consensus Decision Making:

- is a process that allows a group of diverse and similar stakeholders to come to mutual agreement
- allows for the input and agreement of all stakeholders to arrive at a final decision that is not necessarily agreed upon but acceptable to all
- promotes growth and trust between differing stakeholders and stakeholder groups
- allows stakeholder groups to work through their differences
- values the contribution of all stakeholders
- instills a higher level of commitment to the decision-making process and increases engagement of members
- encourages members to acknowledge other points of view, think more creatively and inclusively
- is a more difficult path than majority rules, takes more patience and skillful leadership.

A group committed to consensus may utilize other forms of decision-making (majority rules voting) when appropriate and agreed upon.

Adopted 1/30/17

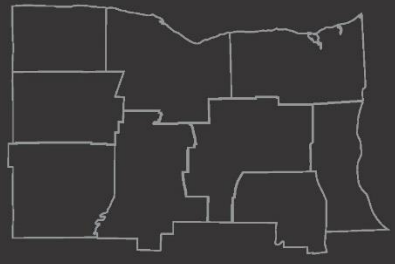
Revised 12/14/18

Revised 5/15/20

Hard Facts Update:

Race and Ethnicity in the Nine-County Greater Rochester Area

AUGUST 2020



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**The cover design is intended to provide a visualization of the ethnic composition that makes up the nine-county region.*

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EXECUTIVE SUMMARY

A. Introduction

What is your impression of our community – the greater Rochester community? We know that our region has many generous and caring people, many effective organizations, resources, and community assets. Yet, something is profoundly wrong.

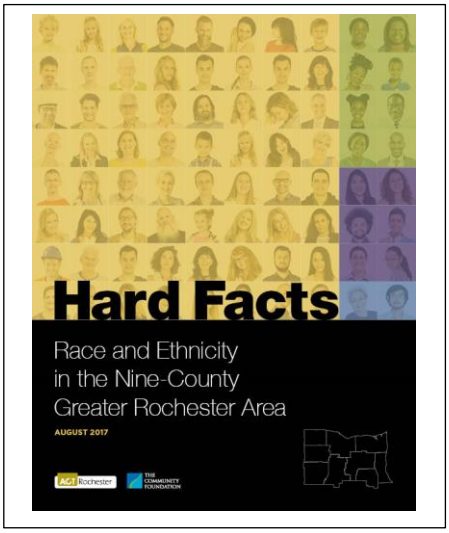
Many people are surprised to learn that we are one of America's most racially segregated communities: We have some of the most segregated schools; we have one of the greatest income disparities in America based on race and ethnicity; we have one of the country's greatest concentrations of poverty[1].

One national study looking at opportunities for children classified greater Rochester as a "hoarder," a place with a lot of resources but tremendous inequality in the distribution of those resources (see p. 11). In fact, this study found the Rochester metro area to be the number one "hoarder" in the entire U.S. Another study of inequality found that the disparity of income between African Americans and Latinos and Whites in Monroe County to be the fifth highest in the United States out of more than 3,100 counties (see p. 19).

While these findings are provocative, they are not surprising given the long-documented disparities and inequalities between people of different races and ethnic groups. The idea that, as a community, we are hoarders is hard to understand and accept. Yet reviewing our community's history reveals that intentional decisions and policy choices by generations of Rochester's leadership have caused gradual and sustained urban development patterns that very effectively divided us by race and then systematically deprived areas of the community occupied by African Americans and, later, Latinos and more recent migrant populations. This pattern is not unique to Rochester but is more intense and more entrenched here than in most places.

This pattern of separation and disparate outcomes not only challenges our sense of justice, it also presents major impediments to achieving regional prosperity. We pay a price in taxes to compensate for our lack of equitable outcomes. More importantly, we pay a bigger price in not fully benefiting from the individual and social capital of all our people. Section 6 of this report analyzes the question: "Does this matter?" The answer is both obvious and not so obvious: This matters greatly – to us all!

This report updates and expands the original *Hard Facts* of 2017. All data have been updated and the report includes observations and analysis in each section.



Like the original, *Hard Facts 2020* seeks to create a deeper knowledge of the disparities confronting African Americans and Latinos in the greater Rochester area. The report aspires to see such knowledge lead to deeper understanding and ultimately to real solutions. The report poses two fundamental questions

1. How do the outcomes for African Americans and Latinos compare with Whites within the nine-county Rochester region[2]?
2. How do the outcomes for African Americans and Latinos in the nine-county Rochester region compare nationwide and in New York State?

Indicators are presented in four categories: Child Health and Well-being; Education Testing Outcomes; Economic Well-being; and Housing and Intergenerational Wealth. These indicators were selected because they reflect impacts over the life cycle of individuals and families and because they are from reputable government sources that are updated regularly and have available detail by race and ethnicity.[3]

Before discussing the report's findings, a word of caution. This report contains many statistical comparisons between racial and ethnic groups. As author Ibram Kendi reminds us, such comparisons should never be viewed as supporting any kind of racial hierarchy. Instead, if we accept the inherent equality of all races and ethnic groups, the outcomes must logically be seen as resulting from policies and practices of our society, both at a national and local level[4]. If we accept the inherent equality stipulated above, then *equity* requires us to redress historical wrongs and attend to closing these disparities.

B. Disparities Within the Region

So, how do the outcomes for African Americans and Latinos compare with Whites within the nine-county Rochester region? The gaps are troubling.

Child Health and Wellbeing

- African Americans are 2½ times more likely than Whites to give birth to low-weight babies; Latinos are twice as likely (only Monroe County data is available).
- For infant mortality, African American children are 3 times more likely to die before age one than Whites, while Latino children are about twice as likely (only Monroe County data is available).
- African American children are nearly 4 times more likely to experience child poverty than Whites, while for Latino children the likelihood is slightly more than 3 times more.

Education Testing Outcomes

- For the foundational Grade 3 English Language Arts, the African American passing rate is slightly less than half (48%) that of Whites, while Latino students tested at slightly more than half (52%).
- For Grade 3 Math, test results were very similar, with African American students at 49% of Whites while Latino students tested at 54%.
- Results for Grade 8 English showed a greater gap, with African American students testing at 35% of the rate for Whites, while Latino students scored at 42%.
- Graduation rates for African American and Latino students have improved in recent years, and both now stand at about 80% of the White rate.

Economic Outcomes

- Compared with Whites in the region, African Americans are almost 3 times as likely to be unemployed, 3 times as likely to live in poverty, and earn incomes that are less than half of Whites in the region.
- Compared with non-Latino Whites, Latinos are 2½ times as likely to be unemployed and 3 times as likely to experience poverty, while earning incomes that are slightly higher than half (53%) of Whites in the region.

Housing and Intergenerational Wealth

- Compared with Whites, African Americans are dramatically less likely to own homes (32% versus 73%); pay a higher percent of income for rent (44% compared with 30%); and, for those who do own homes, realize values that are at only 59% of White homeowners.

- For Latinos, the outcomes are similar: Homeownership is lower (35% compared with 73%); rent burdens are higher (44% of income versus 30%); and home values are lower (68% of White homeowners).

C. Comparing Our Region to the U.S. and NY State

The nine-county Rochester region consists of a large city, three small cities, sprawling suburbs, and extensive rural areas. As such, it is a microcosm of the United States (see p. 7). We would expect outcomes for African Americans and Latinos in our region to be very similar to those in the U.S., but they are not! Compared with African Americans in the U.S., African Americans in the nine-county Rochester region:

- Are more likely to be in poverty (34% compared with 24%);
- Their children are more likely to be in poverty (49%, versus 35%);
- Are more likely to experience unemployment (13.8% compared with 10.6%);
- Have lower incomes (75 cents on the dollar compared with the nation);
- Are less likely to own a home (32% versus 42%);
- Pay a higher percent of income for rent (44% compared to 35%); and
- Own homes of a lower value (less than 50% of the nationwide value).

Education testing outcomes are based on NY State tests. Compared with African American students in NY State, those in the nine-county Rochester region:

- Had a lower passing rate for Grade 3 English Language Arts (25% compared with 45%), and Grade 3 Math (28% versus 43%);
- Had a lower passing rate in Grade 8 English (17% compared with 37%); and
- Had a slightly lower graduation rate (72% versus 75%).

Latinos also lag their counterparts in the nation by significant margins. Interestingly, while outcomes for Latinos within the region are generally slightly better compared with African Americans, the gaps between local and national Latinos are generally about the same or worse. Latinos here:

- Are more likely to be in poverty (32% compared with 21%);
- Their children are more likely to be in poverty (40% versus 28%);
- Are more likely to experience unemployment (10.8% compared with 6.8%);
- Have lower incomes (66 cents on the dollar compared with the nation);
- Are less likely to own a home (35% versus 47%);
- Pay a higher percent of income for rent (44% compared to 32%); and
- Own homes of a lower value (about 46%).

Compared with Latino students in NY State, those in the nine-county Rochester region:

- Had a lower passing rate for Grade 3 English Language Arts (27% compared with 43%), and Grade 3 Math (31% versus 43%);
- Had a lower passing rate in Grade 8 English (20% compared with 39%); and
- Had the same graduation rate (75%).

D. Observations and Analysis

The outcome inequalities noted here are startling and sometimes vexing. For every deficit indicator – poor health, poverty, unemployment, rent burdens – African Americans and Latinos have rates that are meaningfully higher than Whites. For every asset measure – educational testing results, income, and homeownership – African Americans and Latinos have outcomes that often are dramatically lower than Whites.

As stark as the disparities are within the region, the gaps between local African Americans and Latinos and their national or state counterparts are even more concerning. These gaps are a direct result of past and current local patterns of discrimination, such as our legacy of discrimination in manufacturing employment, our zoning exclusion practices and housing discrimination using restrictive racial covenants and redlining, and our community development patterns that have created an exceptional degree of poverty concentration within the City of Rochester. While these practices occurred elsewhere, it is apparent that in degree and impact, they were more intense here.

While many may dismiss past housing discrimination policies as commonplace or distant, African Americans and Latinos likely will continue to grow as a percentage of total population. Therefore, addressing our inequalities has dual importance: economic survival for people who have been marginalized and the need for a collective sense of justice.

E. Changes from Previous Report

This report updates all of the data from the 2017 *Hard Facts* report. Appendices C and D show the changes, which are generally minor. However, there were encouraging and meaningful changes in some of the education data.

F. Finding a Way Forward

This report has illustrated many of our region's most persistent disparities. However, we also recognize that behind every disparity lies an opportunity. It is not the intention of this report to stigmatize people of color or to view them as "problems," but instead to point out how past decisions meted out on racist terms have created a set of conditions that undermine opportunity in our communities of color. Yet there are tremendous opportunities to revitalize our region and realize Rochester's promise by recognizing the inherent value and agency in every person and community.

Section 7 of this report suggests new ways to understand and respond to these challenges. It proposes specific individual and collective actions to develop a deeper understanding of the startling inequalities present in our community. This section also proposes establishing action plans to reverse some of the critical manifestations of our inequalities, specifically the concentration of poverty, the concentration of student poverty, the de-concentration of employment, and the deep residential segregation of our community.

Section 1: INTRODUCTION

A. What Kind of Place is This?

Our community – the greater Rochester community – is a place of great people and great resources. Some of us enjoy a wonderful environment with comfortable homes and neighborhoods and have top-notch health care and excellent schools. Yet this is one of America's most racially segregated communities; we have some of the most segregated schools; we have one of the greatest racial and ethnic income disparities in America; we have one of the country's greatest concentrations of poverty. This is the kind of place we are!

While America struggles to respond to police brutality against African Americans brought to light by the Black Lives Matter movement, there is a growing understanding that police misconduct is symptomatic of the deeper issues of racial oppression and discrimination that have plagued America for centuries. More than half a century after passage of the Civil Rights Act of 1964, the persistence of dramatic disparities in health, education, income, and housing provide a stark testimony to the impacts of segregation and racism at the personal, institutional, and structural levels. In Rochester and beyond, there is a growing realization that Black Kids Matter; Black Schools Matter; Black Homes Matter; Black Incomes Matter.

B. Understanding Race and Ethnicity

Our understanding of the concept of race continues to evolve. Instead of a fixed biological concept, we now know that human variation results from complex patterns of evolution and adaptation. Observed genetic variations are far outweighed by similarities among all humans. Race is increasingly a social concept, not a biological one[5].

Image by American Anthropological Association

Ethnicity is also an evolving concept. Ethnicity generally refers to the culture of people from a specific area. That culture may be defined by language, heritage, religion, and customs. But this concept can also be blurry. The son of an Irish father and a German mother may call himself Irish because his name is easily found on an Irish map of such names. But he is no less German than Irish. So, like race, ethnicity also can be seen as a social construct.

As detailed in Appendices A and B, the racial demographics of the nine-county area include people from all of the racial categories included in the Census data collection system. However, this data also shows that more than 97% of regional residents identify themselves as being of one race: White (82.4%); African American (10.6%) or Asian (2.6%).

More than 81,600 regional residents, or 6.8%, identify themselves as being of Hispanic or Latino ethnic background. Latino is not a racial group, and those who identify themselves as Latinos are members of the various racial groups. Because of the significant disparity in economic and social outcomes, the Census Bureau tracks detailed demographic data for Latinos.

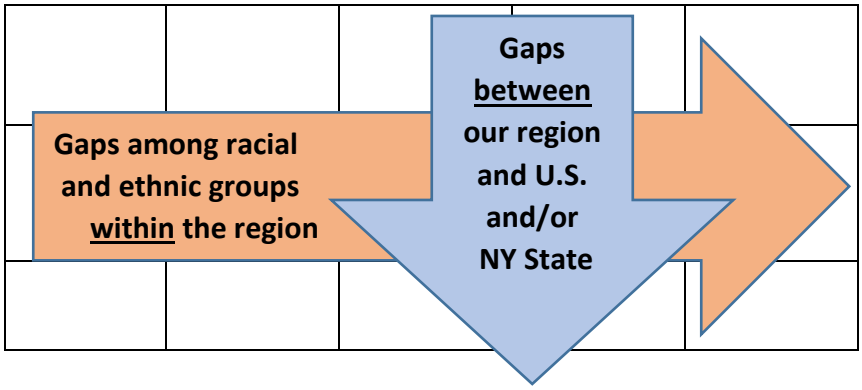
This report will focus on the sharp disparities experienced by African Americans and Latinos. As minorities in a larger society, it is remarkable how similar the outcomes are for African Americans and Latinos, and how different these outcomes are when compared with non-Latino Whites.

This report contains many statistical comparisons between racial and ethnic groups. As author Ibram Kendi reminds us, these comparisons should never be viewed as supporting any kind of racial hierarchy. Instead, if we accept the inherent equality of all, the outcomes must be seen as resulting from policies and practices of our society, both at a national and local level[4].

C. Scope and Method of the Report

This study uses the most up-to-date data from authoritative sources to document and analyze the differences in outcomes experienced by individuals and families in the nine-county greater Rochester area[3]. This report looks at the region as a whole and provides comparisons in two directions:

- Outcomes for different racial and ethnic groups within the region; and
- Outcome comparisons for African Americans and Latinos between the Rochester region and the United States and NY State.



This is not a city-suburb comparison. The nine-county area includes four cities, expansive suburban areas, numerous villages, and significant rural areas. As such, the region should be expected to closely mirror national demographics, and it is very close. Median income in our region is at 95% of the national level; poverty data for the region is the same as the national mark; and homeownership rates here are higher than in the U.S. (all data from the U.S. Census, American Community Survey for 2014-18).

	US	Rochester 9-CountyRegion
Median Income	$60,293	$57,350
Poverty Rate	14%	14%
Child Poverty Rate	20%	20%
Homeownership Rate	64%	68%

While the region's overall data reflects that of the nation, the disparities locally for African Americans and Latinos outpace those in the state and nation -- by meaningful margins.

ACT Rochester has been tracking and reporting most of this data in tabular for several years[6] and its website (ACTRochester.org) contains extensive community indicator data as well as links to important community studies and reports (see APPENDIX F).

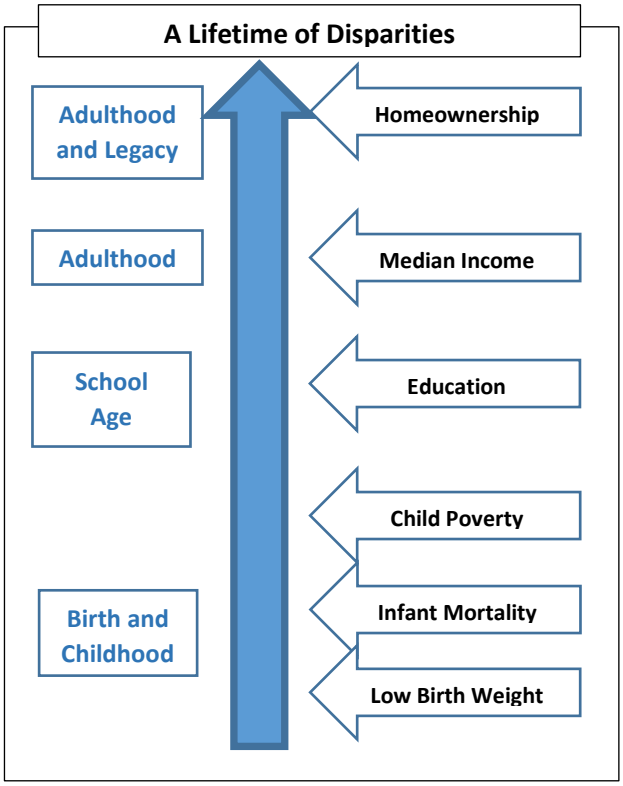
D. Summary of Findings

The *Hard Facts* report, first issued three years ago, documented the great disparity between People of Color and Whites *within* our nine-county region. It also detailed startling disparities for People of Color *between* our region and NY state and the nation. This update shows little change in the numbers, and no change in the three basic findings:

1. Disparities impact individuals and families throughout their lives, and even into future generations. Wide gaps exist in child health and well-being; they continue through a child's academic experience; they persist through the working years; and they impact one of the largest sources of intergenerational wealth transfer – home ownership.

2. The gaps between racial and ethnic groups are greater in the Rochester region than in the United States or New York State as a whole.

3. These results have a demonstrable impact on the well-being of the Rochester region.

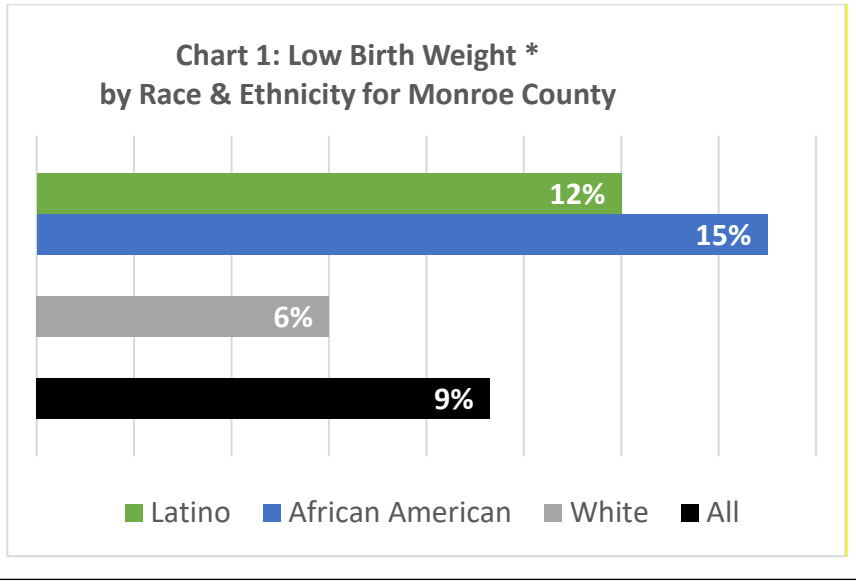


Section 2: CHILD HEALTH AND WELL-BEING

A. Low Birth Weight

Births of less than 5 ½ pounds are a leading indicator of future developmental and neurological problems. In Monroe County, African Americans are 2 ½ times as likely to experience low weigh births as are Whites. The low weight birth rate for Latinos is about 2 times the level of Whites (see Chart 1).

Because we have data only for Monroe County, this indicator does not have comparisons to the U.S. or NY State for people of African American or Latino descent.

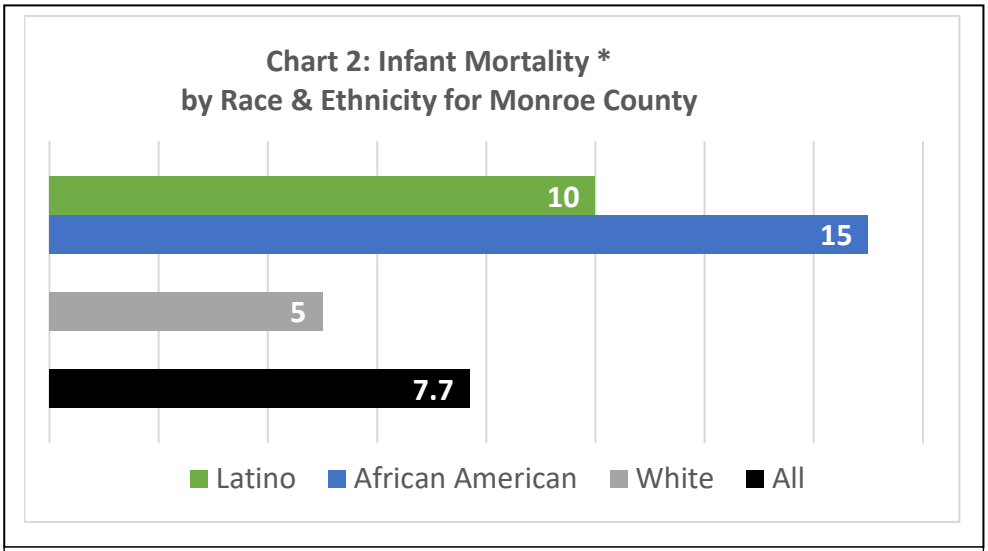


Source: Monroe County Department of Public Health, 2017
** Births of less than 5.5 pounds, as a percent of all births*
Data not available for the Asian population or for other counties in the region.

B. Infant Mortality Rate

Infant mortality rates measure child deaths before age 1 (as a rate per 1,000 live births). African Americans are 3 times as likely as Whites to experience the tragedy of infant mortality, while Latinos have a rate that is 2 times that of Whites (Chart 2).

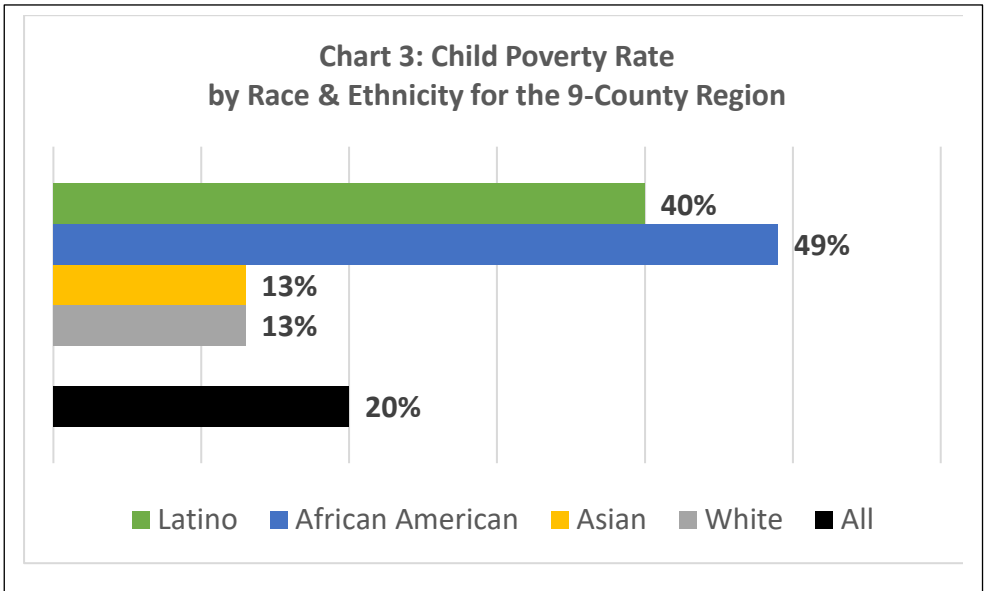
Again, because we have data only for Monroe County, this indicator does not have comparisons to the U.S. or NY State for people of African American or Latino descent.



Source: Monroe County Department of Public Health, 2015-2017
** Deaths before age 1 per 1,000 live births, averaged over 3 years.*
Data not available for the Asian population or for other counties in the region.

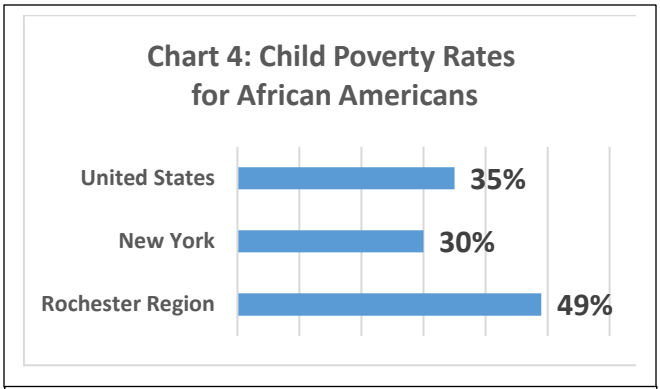
C. Children in Poverty

Child poverty rates in the nine-county region show stark differences among racial and ethnic groups, as well as when comparing our region with both NY State and the U.S. For the nine-county region, African American children have a 49% poverty rate, while the rate for Latino children is 40%. The rate for both Whites and Asians is 13% (see Chart 3).

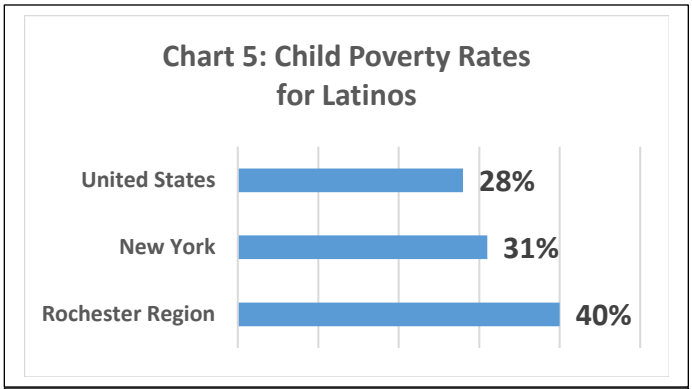


Source: U.S. Census - American Community Survey for 2014-18
Percent of children in households with incomes below the federal poverty level

For both African Americans and Latinos, the regional child poverty rates far outpace both those for NY State and U.S. (see Charts 4 and 5).



Source: U.S. Census - American Community Survey for 2014-18



Source: U.S. Census - American Community Survey for 2014-18

D. Observations and Analysis

As illustrated by the indicators above, the health and well-being of our region's children is highly correlated with race and ethnicity. Nearly 50% of the nine-county region's African American children and 40% of the Latino children live below the very low federal poverty level[7]. Both of these marks are significantly higher than the poverty rates for these groups in the U.S. and NY State.

The gaps between Whites and both African Americans and Latinos have increased for both low birth weight and infant mortality since the 2017 *Hard Facts* report. A longer-term view shows that these gaps have persisted for the past 15 years, with occasional (but minor) year-to-year variations.

For child poverty, the gaps within our region continue to be dramatic but narrowed slightly from the 2017 *Hard Facts* report (2 percentage points for African Americans and 3 percentage points for Latinos). Unfortunately, because African American children saw a greater decrease in child poverty elsewhere, the gap between the nine-county Rochester region and both the U.S. and NY State grew by 2 percentage points. The same reality played out for Latino children, with an absolute reduction in poverty but an increase in the gap from Latinos nationwide (2 percentage points) and from NY as a whole (1 percentage point).

This report contains only a few indicators of child health – those that are reported and updated regularly with race and ethnicity detail. For a deeper understanding of health issues and health disparities, readers are encouraged to consult Common Ground Health, the health planning and research organization for the Finger Lakes Region (CommonGroundHealth.org). Particularly relevant is the work of Common Ground's African American Health Coalition and Latino Health Coalition. Common Ground documents overall health disparities in terms of premature deaths[8].

Child well-being is influenced by a range of factors. The organization Diversity Data Kids recently released a comprehensive Child Opportunity Index for the largest 100 metropolitan areas[9]. This analysis uses 29 indicators of education, health and environment, and economic and social well-being to measure opportunities for children's success. Overall, the Rochester metro area[10] scored reasonably well, just below the top 10 U.S. metros. Alarmingly, the Rochester metro area recorded the highest disparity between high opportunity and low opportunity neighborhoods in the entire United States.

This finding placed Rochester in a category described by the report as “hoarders,” a place with a lot of resources but tremendous inequality.[11]

Widest Child Opportunity Gap	
Metro Area	**Gap**
Rochester, NY	**94**
Detroit, MI	93
Milwaukee, WI	93
Philadelphia, PA	92
Baltimore, MD	91
Buffalo, NY	91
Cleveland, OH	90
Hartford, CT	89
New Haven, CT	89
St. Louis, MO	88
Gap = Difference in opportunity scores between highest and lowest neighborhoods.	

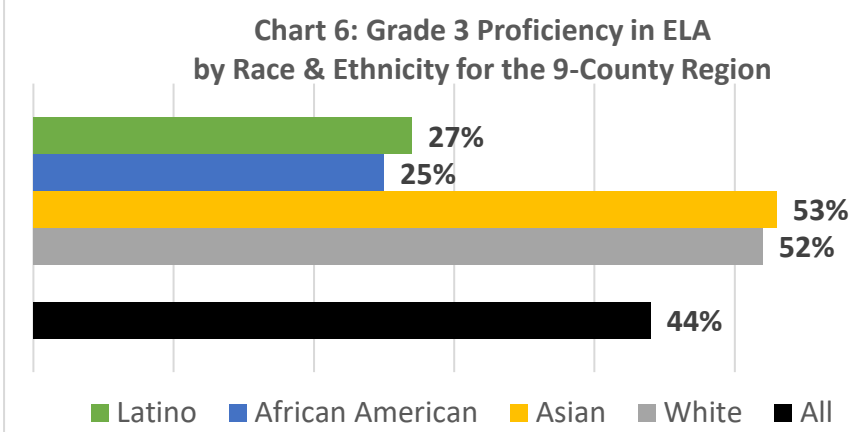
This index is further documentation of the tremendous disparities that exist in our community.

Section 3: EDUCATION TESTING OUTCOMES

Editorial Note: This section was labeled "Academic Achievement" in the 2017 Hard Facts report. It has been changed here to be more descriptively accurate[12]. Also, since Grade 8 Math results are not available by race and ethnicity, Grade 3 Math is used here instead. Grade 8 English was shown in an appendix in the 2017 Hard Facts report.

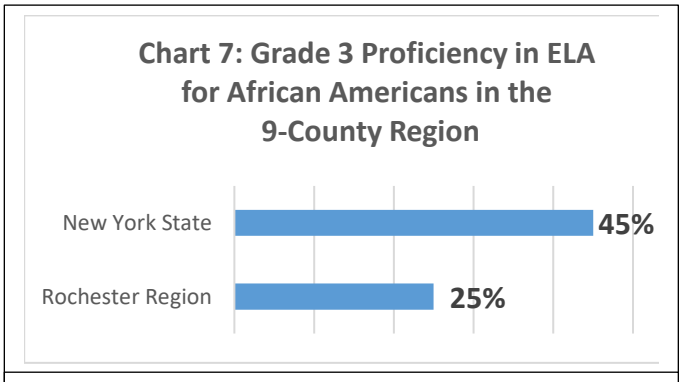
A. Grade 3 English Language Arts (ELA)

Grade 3 reading level is often cited as a critical milestone in a child's education. The observation is that if a child can "learn to read" by this point, he or she will be able to "read to learn" in later grades. As shown on Chart 6, only 27% of Latino students and 25% of African American students in the nine-county region achieve this milestone, compared with 52% of White students and 53% of Asian students.

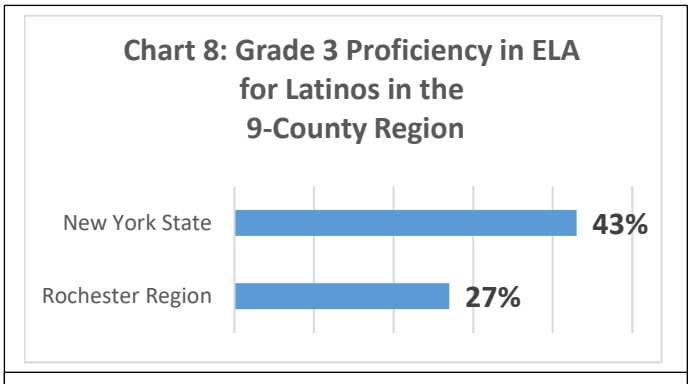


Source: NY State Department of Education, student assessments for 2019.
Percentage of students testing at proficient level (level 3) or above (level 4).

Of crucial concern, Latino and African American students in our region lag behind students of the same groups in NY State, and by a very large margin (Charts 7 & 8). Why would African American students in our region (urban, suburban, rural) succeed at 20 percentage points lower than the rate for African American students throughout NY State (urban, suburban, rural)? The disparity for Latino students is somewhat lower (16 percentage points), but also dramatic and without a ready explanation.



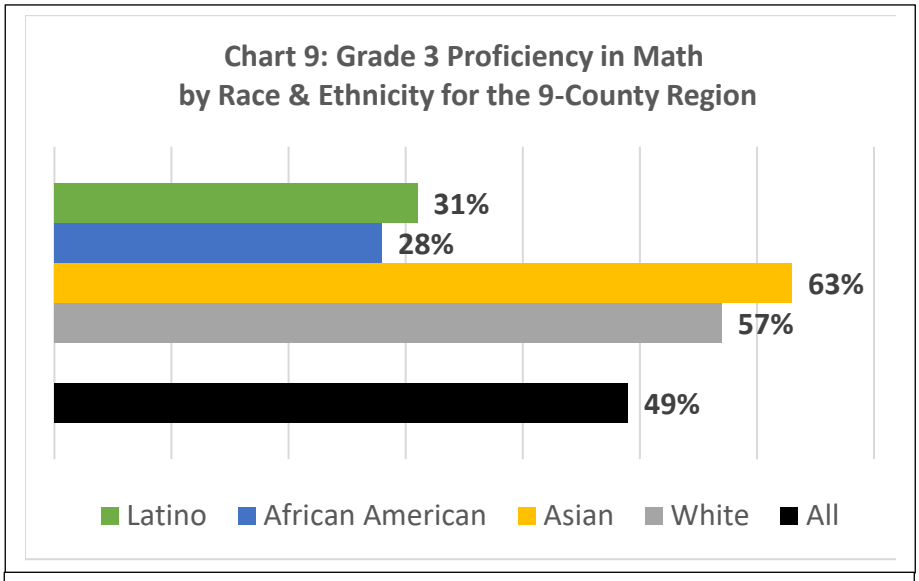
Source: NY State Department of Education, student assessments for 2019. Percentage of students testing at proficient level (level 3) or above (level 4).



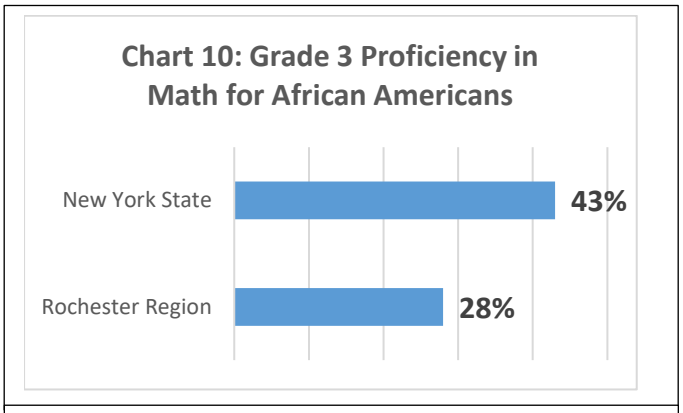
Source: NY State Department of Education, student assessments for 2019. Percentage of students testing at proficient level (level 3) or above (level 4).

B. Grade 3 Math

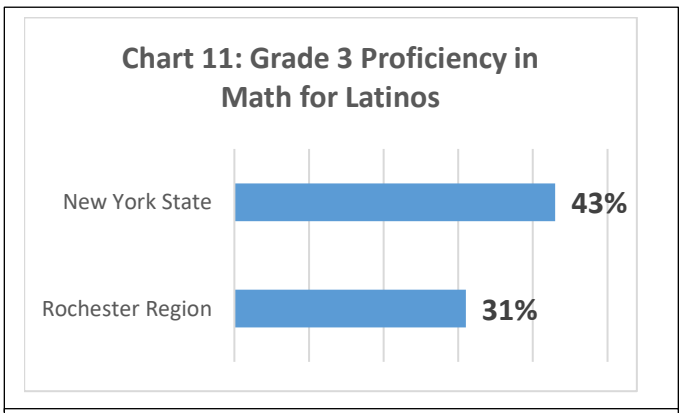
Looking at Math for Grade 3, we find gaps of a similar magnitude among racial and ethnic groups, and between our region and the state (Charts 9, 10, & 11).



Source: NY State Department of Education, student assessments for 2019.
Percentage of students testing at proficient level (level 3) or above (level 4).



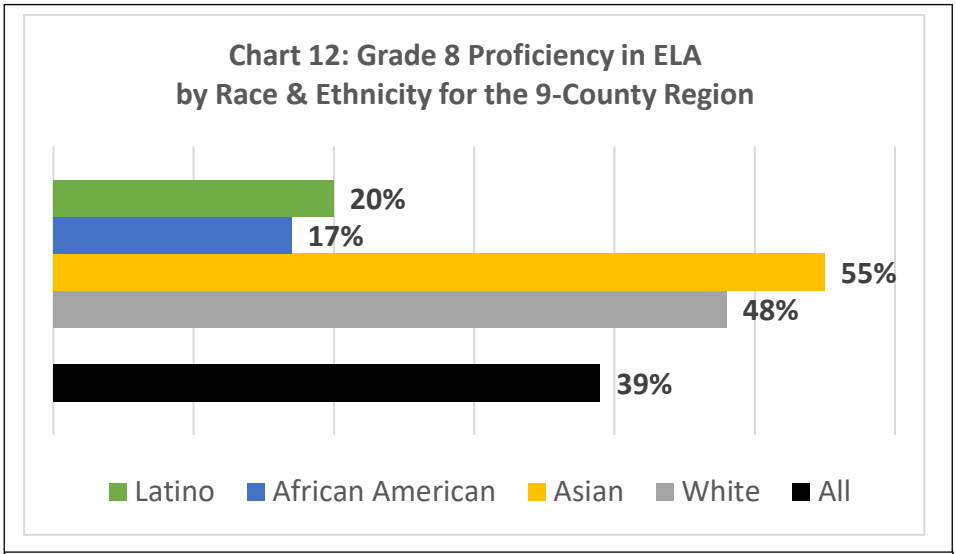
Source: NY State Department of Education, student assessments for 2019. Percentage of students testing at proficient level (level 3) or above (level 4).



Source: NY State Department of Education, student assessments for 2019. Percentage of students testing at proficient level (level 3) or above (level 4).

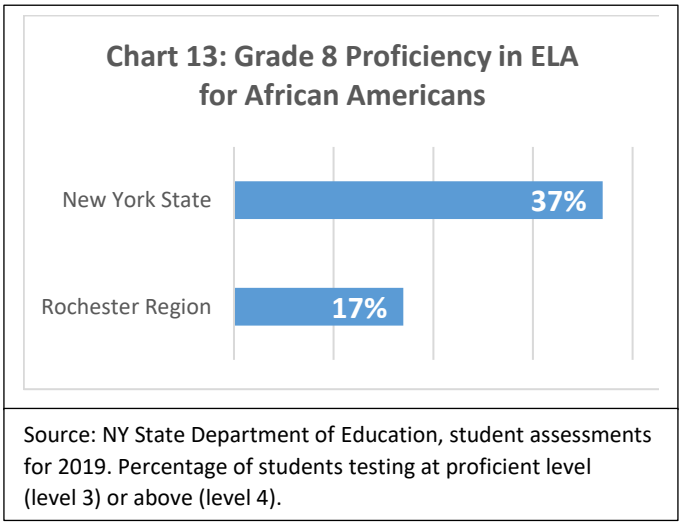
C. Grade 8 English Language Arts (ELA)

Looking at the other end of the age spectrum, Grade 8 English scores show an even greater disparity among racial and ethnic groups. There is a 31-percentage point gap in the proficiency rate between African Americans and Whites, while there is a 28-percentage point gap between Whites and Latinos (Chart 12).

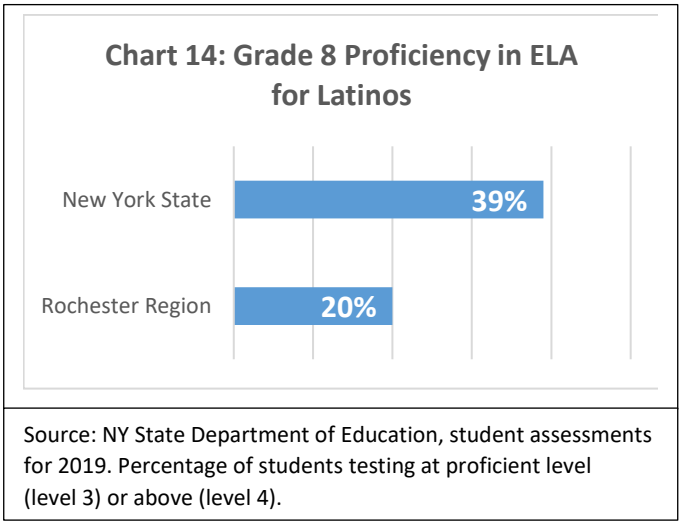


Source: NY State Department of Education, student assessments for 2019.
Percentage of students testing at proficient level (level 3) or above (level 4).

More striking is the gap in Grade 8 results for the same groups in the nine-county Rochester region and NY State as a whole. African Americans in the Rochester region scored at less than half that of African Americans throughout New York, while Latinos locally scored at only slightly more than half the level of Latinos statewide (Charts 13 and 14).



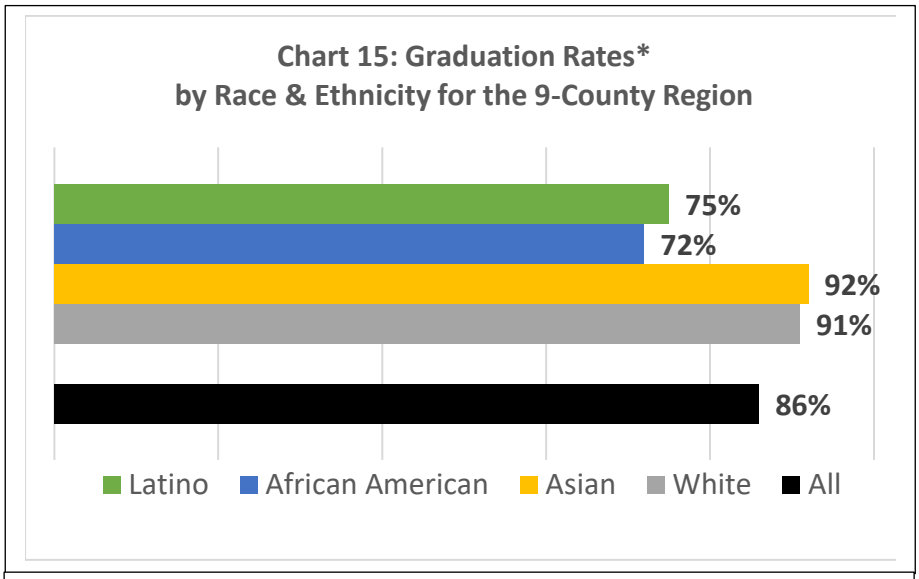
Source: NY State Department of Education, student assessments for 2019. Percentage of students testing at proficient level (level 3) or above (level 4).



Source: NY State Department of Education, student assessments for 2019. Percentage of students testing at proficient level (level 3) or above (level 4).

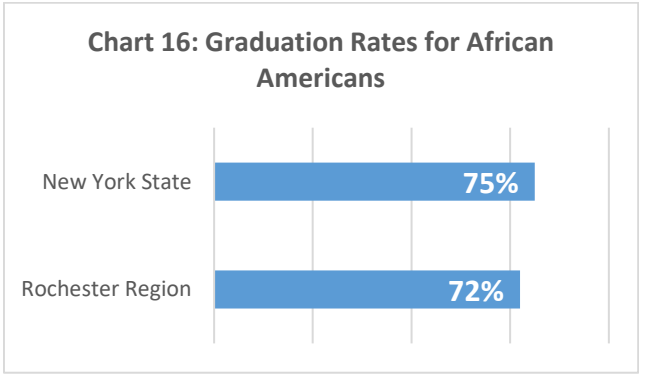
D. Graduation Rates

In education, much attention is focused on graduation rates. As shown in Chart 15, graduation rates within our region exhibit drastic disparities, though the gaps in graduation rates are somewhat less stark than those for education testing outcomes.

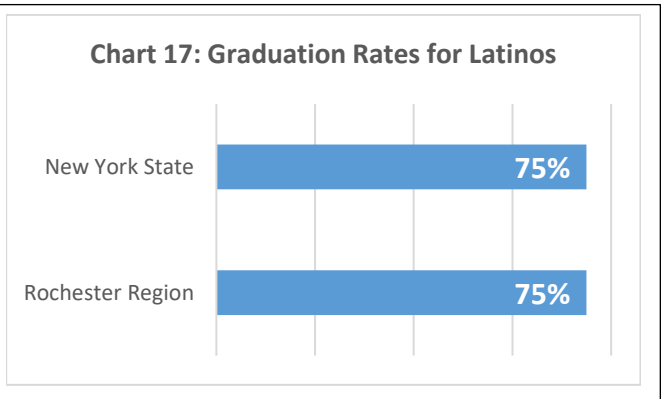


* Four-year graduation rate in 2019
Source: NY State Department of Education

With recent improvements in local graduation rates, the gap for African Americans and their statewide counterparts has narrowed significantly. There currently is no gap for Latinos.



Source: NY State Department of Education,
Four-year graduation rate for 2019.



Source: NY State Department of Education,
Four-year graduation rate for 2019.

E. Observations and Analysis

Substantial disparities among racial and ethnic groups within our region continue in all education outcomes. For the most part, the Rochester region's African American and Latino students also lag their statewide counterparts. However, there are meaningful improvements since the 2017 *Hard Facts* report. Absolute test scores and graduation rates for African Americans and Latinos, as well as the gaps between these groups and White students, have improved for all indicators from the 2017 report.

Though still significant, the disparity between African American and Latino students in the Rochester region and their statewide counterparts has narrowed or remained unchanged. Particularly heartening is the improvement in graduation rates, where Latinos are now on par with statewide Latinos, and where African American students are very close to the statewide mark for African Americans. Also promising are the results for Grade 3 English Language Arts (ELA), where the gap between African American students and their White classmates has narrowed by 7 percentage points.

While this report focuses on the nine-county region, it is clear that success in the Rochester City School District plays an important role in these regional outcomes. ROC the Future is a community collaborative that focuses on strategies to improve outcomes. See reports on a range of indicators impacting Rochester City schools at RocTheFuture.org.

Section 4: ECONOMIC WELL-BEING

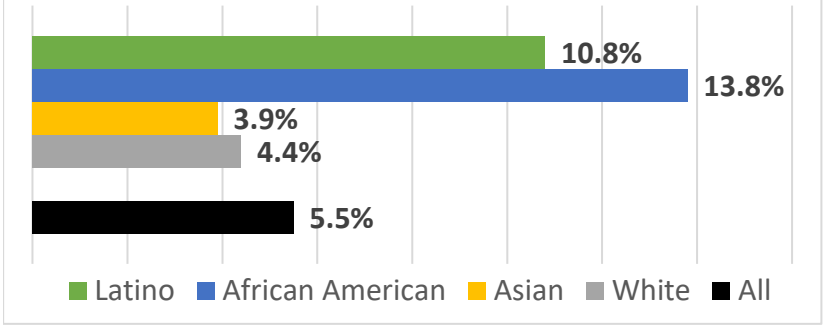
A. Unemployment[13]

Disparate economic outcomes in our region parallel the gaps seen in earlier life.

African Americans are about 3 times more likely to be unemployed compared with Whites in our region, while the gap for Latinos is about 2 ½ times (Chart 18).

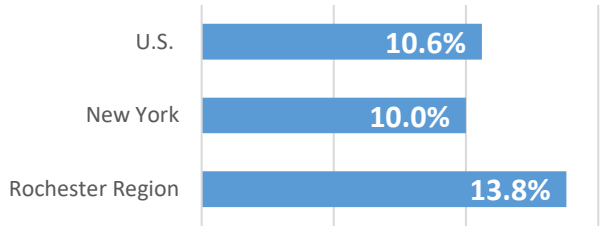
As shown in Charts 19 and 20, unemployment experiences for African Americans and Latinos in our region significantly exceed those of African Americans and Latinos in both the U.S. and NY State.

Chart 18: Unemployment Rates by Race & Ethnicity for the 9-County Region



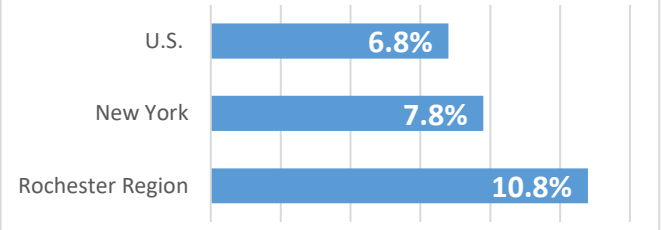
Source: U.S. Census, American Community Survey for 2014-18.
Percent of those in the workforce experiencing unemployment during 12 month period (see endnote 11).

Chart 19: Unemployment Rates for African Americans



Source: U.S. Census, American Community Survey for 2014-18
Percent of those in the workforce experiencing unemployment during 12-month period (see endnote 11).

Chart 20: Unemployment Rates for Latinos



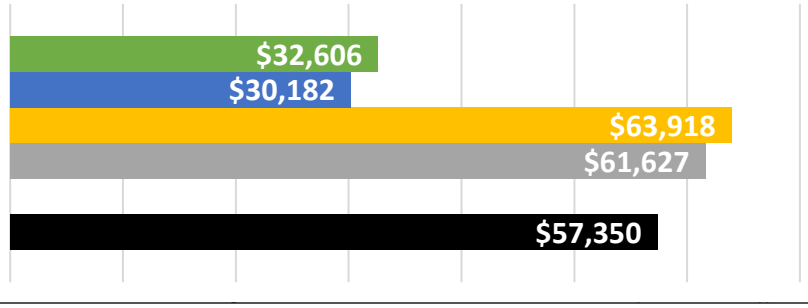
Source: U.S. Census, American Community Survey for 2014-18
Percent of those in the workforce experiencing unemployment during 12-month period (see endnote 11).

B. Income

The median income for local African Americans amounts to less than 50% that of Whites. For Latinos, the median income is slightly higher than 50% that of Whites (Chart 21).

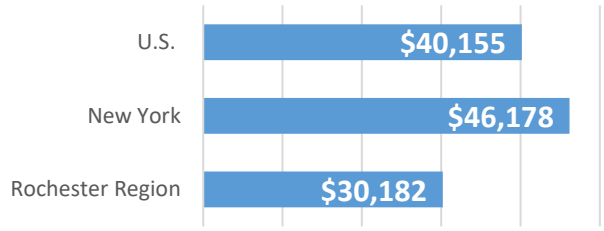
Incomes of local African Americans are equal to only 75% of Blacks nationwide. For Latinos incomes are even lower (66%) when compared with their counterparts nationwide (Charts 22 and 23).

Chart 21: Median Household Income by Race & Ethnicity for the 9-County Region



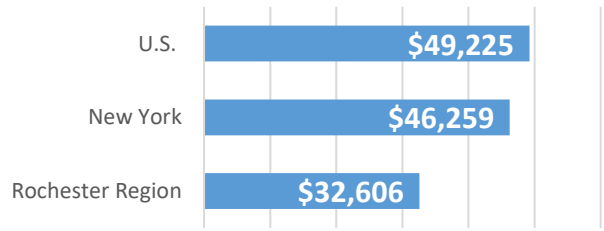
Source: U.S. Census, American Community Survey, 2014-18.

Chart 22: Median Household Income for African Americans



Source: U.S. Census, American Community Survey, 2014-18.

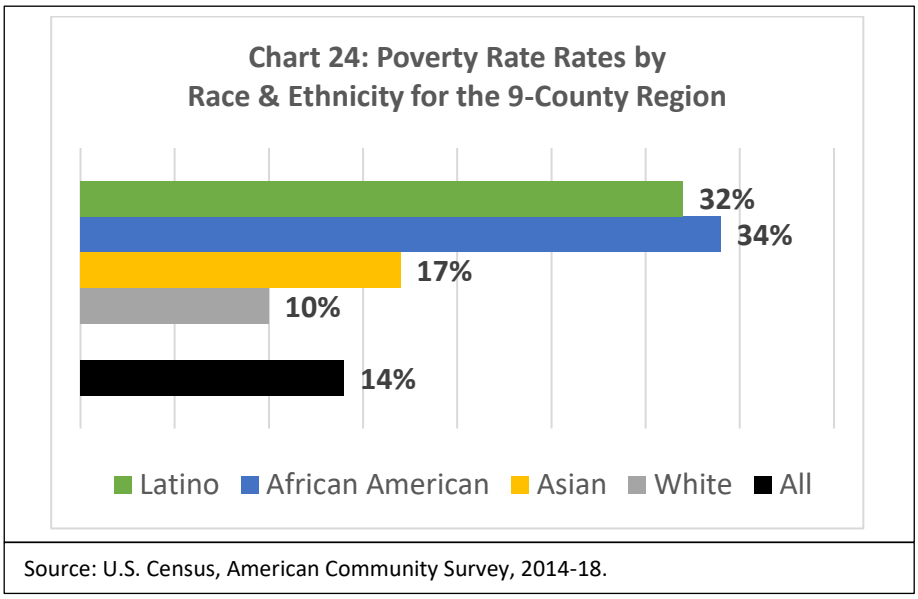
Chart 23: Median Household Income for Latinos



Source: U.S. Census, American Community Survey, 2014-18.

C. Poverty

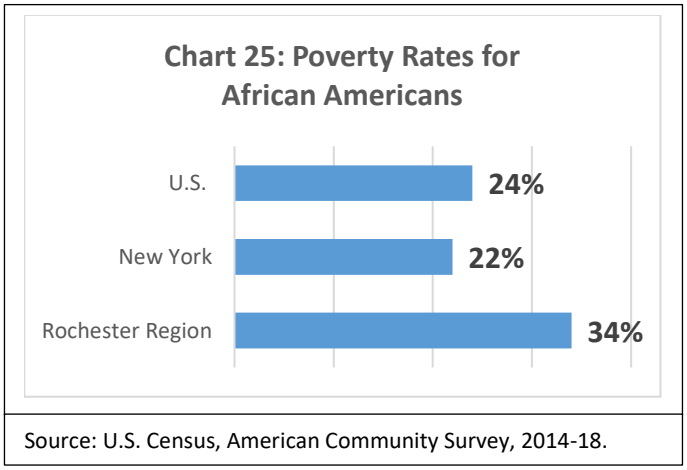
Chart 24 shows the dramatic – it would be fair to say extreme – disparity in poverty rates within the nine-county region. Both African Americans and Latinos experience poverty at a rate that is more than 3 times that of Whites. The data here is the percentage of all people in each racial and ethnic group with incomes below the federal poverty line -- well below what is required to meet basic needs[5].



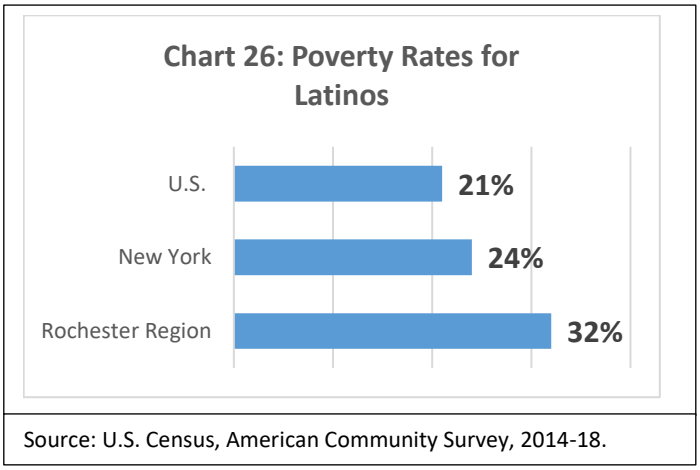
Source: U.S. Census, American Community Survey, 2014-18.

The poverty rate of African Americans in our region is 42% higher (10 percentage points) than experienced by African Americans in the U.S. It is 55% higher than the NY State mark (Chart 25).

The poverty rate for Latinos in our region is 52% higher than for Latinos in the U.S. and 33% higher than NY State (Chart 26).



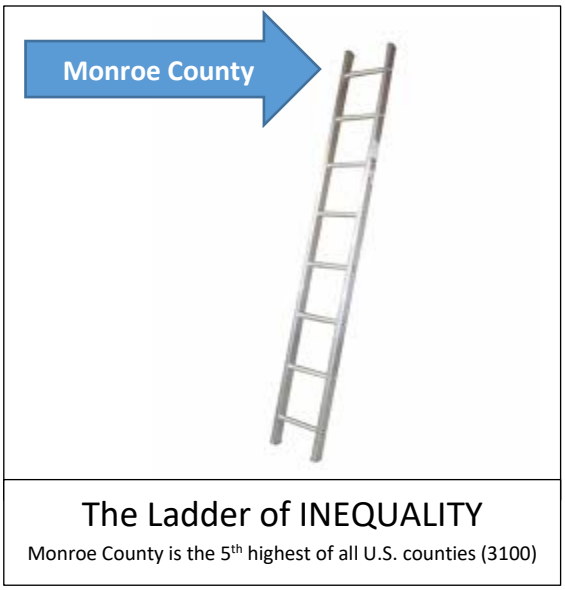
Source: U.S. Census, American Community Survey, 2014-18.



Source: U.S. Census, American Community Survey, 2014-18.

D. Observations and Analysis

Economic disparities within our region and in comparison to the nation and state are extraordinary. These disparities – way out-of-line with the national and statewide experience – reflect a type of racism that must be stopped if our region is to prosper.



Consider a recent Brookings Institution finding regarding income disparity within Monroe County, our region's core county[14]. Of more than 3,100 counties in the nation, Monroe recorded the fifth highest income disparity between Whites and African Americans and Latinos.

This places Monroe near the pinnacle of inequality. Statistically, this means that 99.840815% of all American counties have a more equitable income distribution when it comes to race.

Compared with the 2017 *Hard Facts* report, this data reflects very minor improvements in economic disparity. This is especially the case in the unemployment rate gap, which shrunk by 2.6 percentage points for African Americans and less than 1 percentage point for Latinos. African American incomes rose very slightly compared with Whites, but Latino incomes declined very slightly compared with Whites. The poverty rate gap between Whites and both African Americans and Latinos declined by 1 percentage point.

Unfortunately, gains by African Americans and Latinos nationwide and statewide outpaced those in our region. While the changes are too small to be considered statistically significant, trends should be watched to see if they continue.

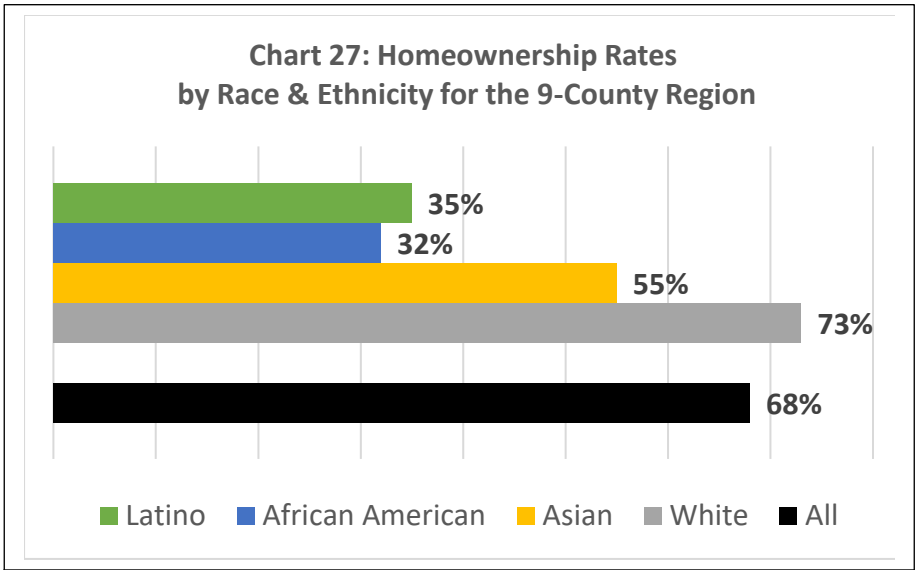
None of the economic indicators above reflect the impact of the COVID-19 virus. It has been widely reported that these impacts have disproportionately hit African Americans and Latinos. Data from the Monroe County Public Health Department shows that through mid-July of 2020, compared with Whites, African Americans experienced 4 times as many COVID-19 cases, nearly 5 times the COVID-19 hospitalization rate, and 2.3 times the COVID-19 death rate. For Latinos, the case rate compared to Whites was 2 ½ times higher, and the hospitalization rate was 3.3 times higher. The Latino COVID-19 death rate was not reported as the data was not considered to be stable given the small number of deaths [15].

The economic impacts of the COVID-19 pandemic will almost certainly be felt more dramatically by People of Color. Current reports already indicate a disproportionate impact on unemployment[16]. The long-term impact of the virus and the recovery should be monitored closely.

Section 5: HOUSING AND INTERGENERATIONAL WEALTH

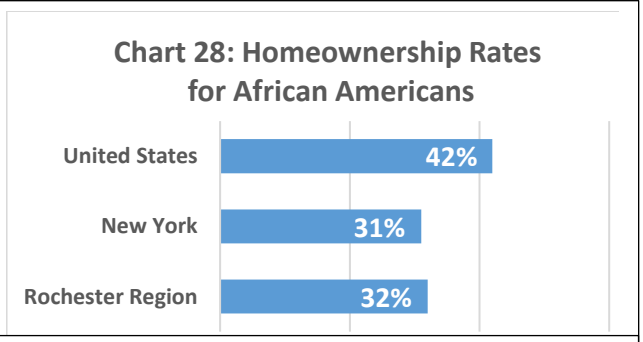
A. Homeownership

For some, the decision to own or rent a home is a lifestyle choice. But for a large part of our society, it is a matter of economics. So, it is not surprising that disparities in homeownership mirror the income gaps previously described. Both African Americans and Latinos in the nine-county region are less than half as likely as Whites to own the home in which they live (Chart 27).

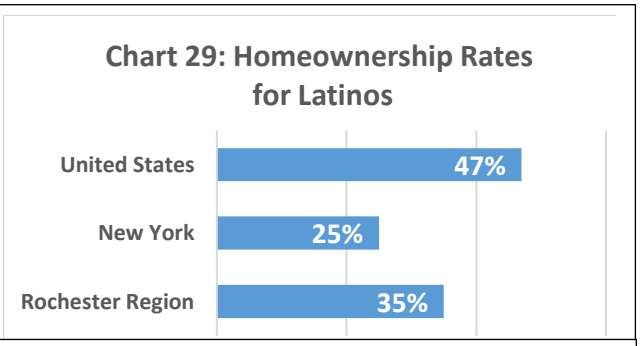


Source: U.S. Census, American Community Survey, 2014-18.

African Americans and Latinos in our region are significantly less likely to own a home, compared with African Americans and Latinos in the U.S. as a whole (Charts 28 and 29). This is particularly concerning since homeownership is considerably less expensive here than elsewhere. Reflecting this relative affordability, more of all regional residents (68%) own homes when compared with the nation (64%). Yet even where our region has a relative advantage over other parts of the nation, that advantage is not realized for African Americans and Latinos.



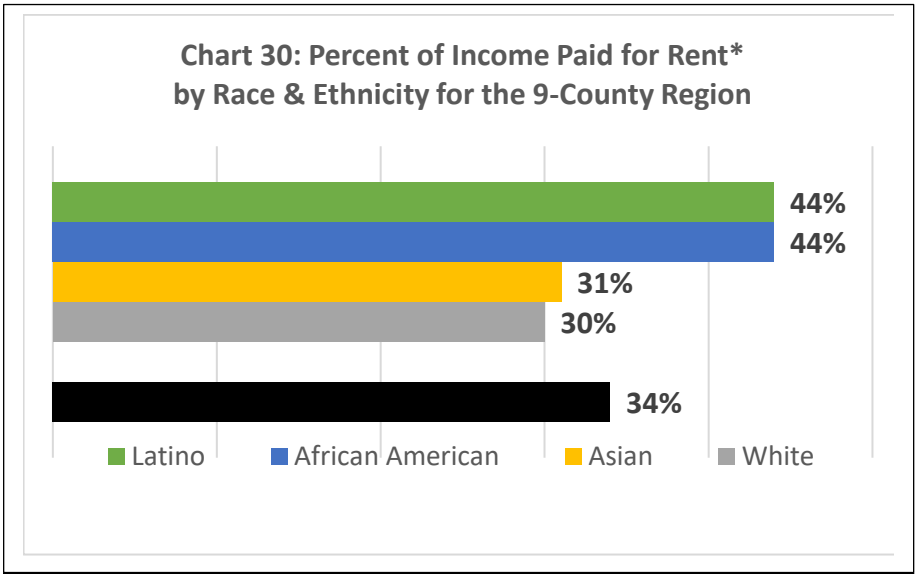
Source: U.S. Census, American Community Survey, 2014-18.



Source: U.S. Census, American Community Survey, 2014-18.

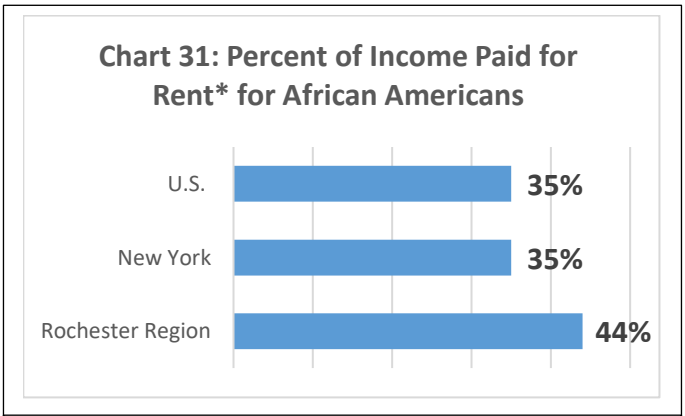
B. The Cost Burden of Renting

Approximately two-thirds of African Americans and Latinos rent, and they face a greater challenge than Whites in being able to afford their rents. As shown in Chart 30, African Americans and Latinos in our region both pay 44% of their income in rental costs. Only White renters are able to meet the informal benchmark of no-more-than 30% of income for rent. This reality is primarily a reflection of income disparities; we know from other research that there is not a great gap in our region in the amount paid for rents by people of different racial and ethnic groups[17].

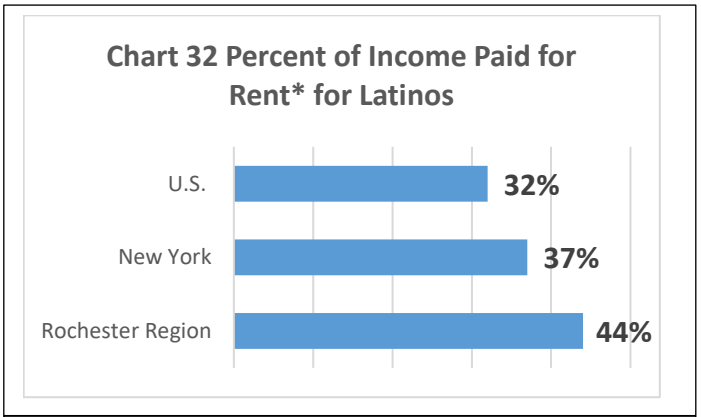


Source: U.S. Census, American Community Survey, 2014-18.
* "Gross Rent": monthly rent plus utilities and fuel.

Again, the disparity in the nine-county Rochester region is great enough that both African Americans and Latinos here exceed their national counterparts in the percent of income spent for rent (Charts 31 and 32). Interestingly, the percent of income paid for rent locally exceeds the NY State mark, despite the dramatically higher rental costs in in the New York City area. This suggests that the income disparity is greater than the rental cost differences.



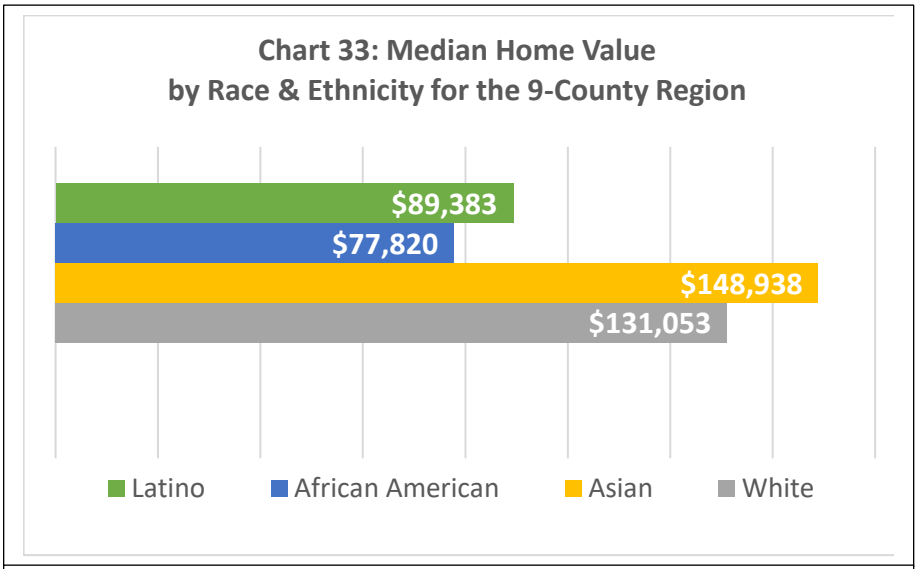
Source: U.S. Census, American Community Survey, 2014-18.



Source: U.S. Census, American Community Survey, 2014-18.

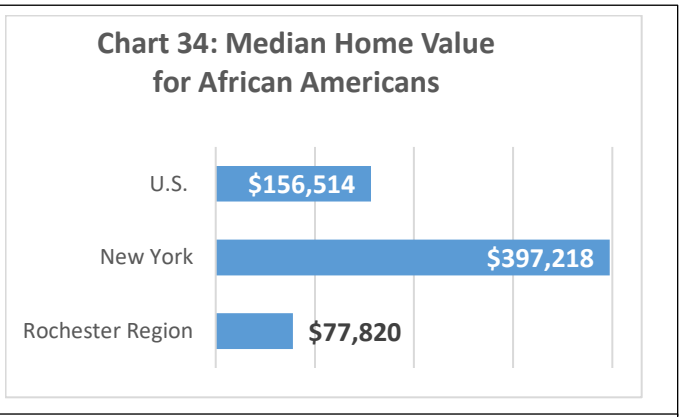
C. Median Home Value

For African Americans and Latinos who do own homes, the values of their homes are dramatically lower when compared with the value of homes owned by Whites in our region (Chart 33).

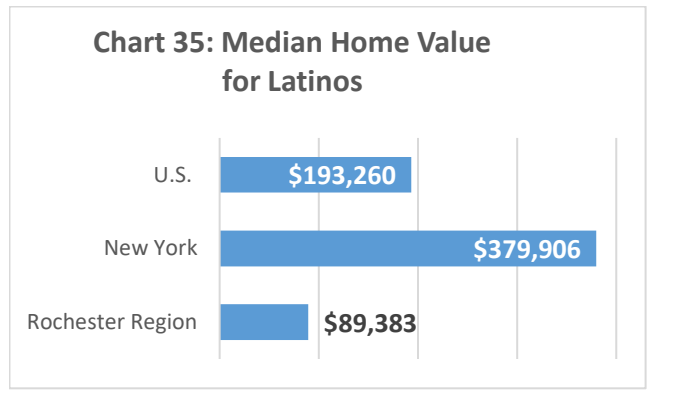


Source: U.S. Census, American Community Survey, 2014-18.

For both African Americans and Latinos, the value of homes owned in the nine-county region is dramatically lower (less than half) than the nation as a whole. This is partially the result of our region's overall lower home costs. For Whites in the region, home values equal about 61% of the nationwide value for Whites.



Source: U.S. Census, American Community Survey, 2014-18.



Source: U.S. Census, American Community Survey, 2014-18.

D. Observations and Analysis

The housing data presented above paints a complex picture of the realities faced by African Americans and Latinos in our community. Some quick observations from the data:

- More than two-thirds of African Americans and slightly less than two-thirds of Latinos in our region live in rental homes, compared with about one-quarter of Whites. Homeownership is often seen as the signature of the American Dream. Owning one's home generally represents an important step on the economic ladder. It also can bring a meaningful improvement in quality of life. The equity in one's home is one of the most common means by which families and individuals pass assets to younger generations

- African Americans and Latinos who rent pay 44% of income for rents, considerably higher than Whites (30%), and higher than the 30% ceiling considered economically sustainable. This leaves considerably less income for the other necessities of daily living.

- For African Americans and Latinos who own, home values are less than half that of Whites. This reflects income disparities. But it also is likely to reflect policies and practices that have prevented, discouraged, or intimidated African Americans and Latinos from living in areas of higher value[18]. The average "value deficit" compared to White home values is $53,233 for African Americans and $41,670 for Latinos. This "value deficit" contributes to a significant wealth gap, which reduces wealth that is passed along to younger generations.

Section 6: WHY WE NEED TO ACT

A. Real Facts – Real People

Truly, these are hard facts. They are hard to accept because they undermine sense of community. They are hard facts because they are hard to explain. Without a common understanding of what these facts mean, and how they came to be, it is easy to rationalize explanations that are based on no facts at all.

These are also hard facts in the sense of being solid. This data has been reported for many years by reputable government sources. The data are not perfect (no data really are), but the information is reliable and should not be ignored.

While this data is real, it is important to remember that the percentages represent people. Instead of "infant mortality rate" we should envision the tragedy of an infant death and remember that reality is 3 times as likely for African Americans than Whites in our region. Instead of "childhood poverty rate" we should consider the material and emotional stress on a toddler growing up in an impoverished family, and again remember that both African American and Latino children are more than 3 times as likely to experience this stress. Behind every number in this report are real people struggling to meet the challenges of life, struggles that are made more difficult by staggering and persisting inequalities.

Disparities, gaps, inequalities! These seem to be the key words whenever there is a serious analysis of our region. So often, our study work is headlined as: disparities between Blacks and Whites; gaps between those of means and those without; inequalities between city and suburbs that have persisted for decades. While there may be a tendency to explain away these inequalities as a reflection of society's ills, the fact that the Rochester region fares more poorly on almost every indicator suggests there is something local that must be fixed. Perhaps it is our extreme concentration of poverty, or our exceptionally segregated communities. Or maybe an entrenched resistance to change.

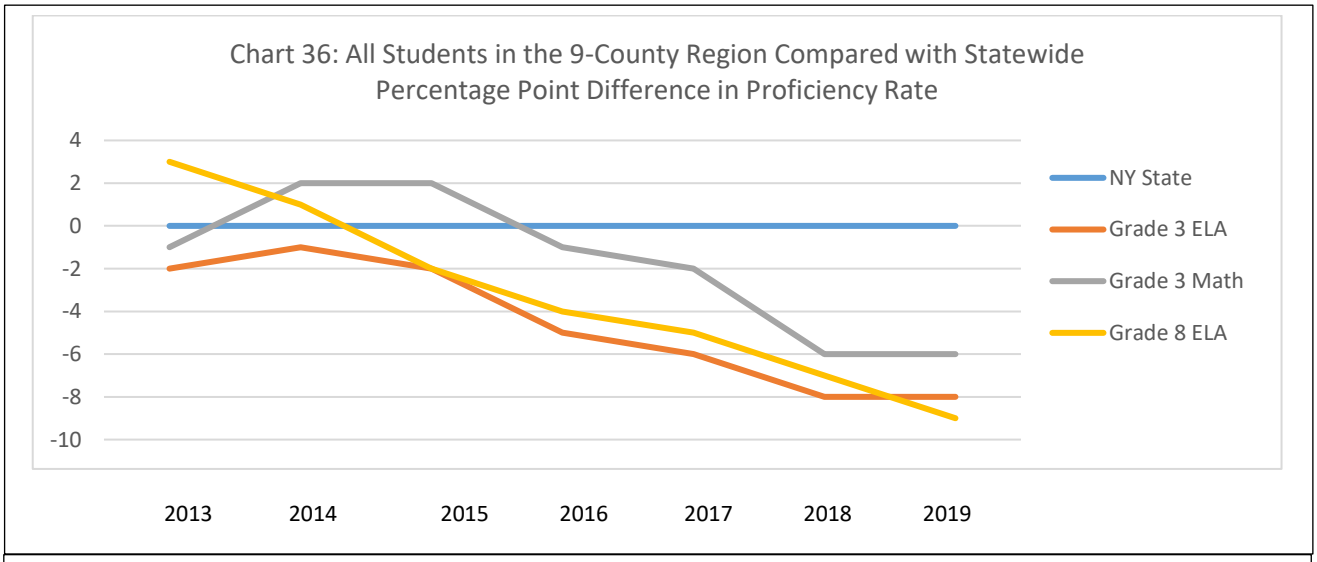
B. Why it Matters

Beyond personal conscience and civic pride, does it matter if we address these issues? After all, we are very segregated. Most people in our regional community do not regularly see the people behind these numbers. Of course, it matters for reasons of conscience and pride. But it also matters for the economic well-being of our region.

Consider our poverty rates. African Americans and Latinos in our nine-county region experience poverty at a rate considerably higher than their counterparts in the nation (Charts 25 and 26). We do not know the reason for this, so we should assume our region can achieve those national levels. As described in the table below, regional poverty rates at the national level for People of Color would result in our region having about 21,800 fewer people in poverty – which works out to about half the population of the town of Webster. In addition to higher dignity for 21,800 people, we would have significantly reduced public support costs, and greater local tax revenues. This simply makes sense – if more people share in the resources of the region, we all benefit.

Reduction in Poor Population if National Poverty Rates were Achieved Here						
Group	**Current Nine-County Population (Appendix A)**	**Current Poverty Rate (Charts 25 & 26)**	**People in Poverty (rounded)**	**National Poverty Rate (Charts 25 & 26)**	**People in Poverty at the National Rate (rounded)**	**Difference**
African Americans	128,359	34%	43,600	24%	30,800	**12,800**
Latino	81,627	32%	26,100	21%	17,100	**9,000**
Total						**21,800**

In another example of how racial and ethnic disparities impact the entire region, we should consider how educational testing scores in our region are becoming less competitive with other parts of NY State. The 2017 *Hard Facts* report noted a gradual decline in regional scores for all students between 2000 and 2016[19]. That decline has continued to the point that the nine-county region constantly lags statewide results – for all students. Chart 36 below compares our region's results to statewide results for the same tests in the same year.



Source: NY State Department of Education, as reported by ACT Rochester (ACTRochester.org)

The implications of this table are enormous. Our region, historically a statewide leader, is being consistently outperformed. And, the pattern has been getting consistently worse, especially in the most recent five years. Some, of course, will think of this as a "city problem" in light of the Rochester City School District's academic struggles. But consider this: In 2019, not one of the 9 counties achieved the statewide mark for Grade 3 English; only one county (Wyoming) exceeded the state level for Grade 3 Math; and only one county (Ontario) exceeded the state result for Grade 8 English.

Remember, this table is for all students. We do not know the degree to which these results stem from lower scores by our region's students of color. But the disparities between those students and their statewide counterparts are very significant (Charts 7, 8, 10, 11, 13, and 14), meaning that the disparities contribute meaningfully to our region's underperformance. Why do students of color struggle in our region?

These are just two examples of how failing to provide equitably hurts the entire region. There are many other examples. While a basic sense of justice compels us to act on the inequalities described here, we should also see that greater justice will bring greater community progress.

Section 7: WHERE DO WE GO FROM HERE?

This report has illustrated many of our region's most persistent disparities. However, we recognize that behind every disparity lies an opportunity. It is not the intention of this report to stigmatize People of Color or to view them as "problems," but instead to point out how past decisions meted out on racist terms have created a set of conditions that undermine opportunity in our communities of color. Yet there are tremendous opportunities to revitalize our region and realize Rochester's promise by recognizing the inherent value and agency in every person and community. Each child lost to infant mortality or afflicted with childhood poverty could, but for structural racism and its attendant disparities, contribute to Rochester's vitality. As we recognize the disparities, we must also remain cognizant of the strengths and rich assets that our communities of color possess. Even in accounting for the disparities, we would do well to remember that these assets must also be recognized and built upon.

So, what response should we have to these disparities and opportunities – as individuals and as a community? Many times, discussions around racial equity start and stop at the individual response. However, we have already observed how a communitywide lens is necessary to understand and make progress in closing these disparities and realizing opportunities. Indeed there are already communitywide structured initiatives to improve education (ROC the Future) and reduce poverty (Rochester-Monroe Anti-Poverty Initiative), two areas where racial and ethnic disparities are significant In addition, there are many other organizations fostering equity in our community. In June 2020, Rochester Mayor Lovely Warren and Monroe County Executive Adam Bello announced the formation of a **Commission on Racial and Structural Equity** "to examine and develop policies and legislation to overcome systemic and institutional inequities, as well as racism in Rochester and Monroe County[20]." In August 2020, the 21-member commission was named.

These efforts are heavily dependent on broad support from all sectors of our community, including businesses and other employers, governments throughout the county, educators throughout the county, community organizations, and the public at large.

Nibbling at the edges while preserving the current economic paradigm will only exacerbate our challenges as we lose ground to other regions that are taking bold steps to address poverty and structural racism. Our community needs to embrace innovation and look for big ideas. Consider asking ourselves: What if?

1. What if we realized that the majority of jobs and opportunities are held by suburban and White people, and that has an effect on People of Color, particularly in the City of Rochester. Even municipal jobs and those in nonprofits that *service* the city population are held by people who live outside the city. Can we really anticipate major change if we are unwilling to tackle this bedrock fact? Is it time for us to consider investment in communities of color as a response to the economic reality of resource flow from the city? What could that look like?

   What if we talked about residency requirements or commuter taxes as ways to capture revenue that can be reinvested into the city? Funds that are collected in this manner could be used explicitly for anti-racist purposes to create more economic mobility and growth for People of Color in the city.

2. What if our history leads us on a trail to possible solutions? We know that the natural economic growth that was occurring for African Americans in the Clarissa Street section of the city was

stopped with urban renewal after the 1964 uprising. History tells us that policies like redlining and restrictive covenants were created with explicit racial intent[21].

Many current policy responses tend to be race neutral, ignoring the explicitly non-neutral nature of past policies. These types of policies do not redress past injustice and continue to repeat inequalities. Do our policies and responses need to be explicitly anti-racist in form and function?

3. What if our approach to issues of poverty and race has been too individually focused? Thinking of poverty as an individual phenomenon limits the imagination and forces us into unworkable solutions that are not up to the scale of the problem. Approaches to create *self-sufficiency* or reach certain income thresholds for individuals may need to be amended to consider the creation and supplementation of healthy interdependent networks that require us to think differently about how communities are resourced.

Let us suggest some specific goals for communitywide collective action:

1. Conduct **communitywide conversations about race, racism, and inequality**. Such conversations should be well-planned, held throughout the region, and aimed at providing education regarding the explicit historical origins of current inequalities.

2. Develop goals and a plan to reduce our region's exceptional **concentration of poverty**[22]**,** specifically in the City of Rochester. There are three broad strategies to achieve this: reduce poverty, attract more people of means into the city, and expand housing opportunities outside of the city for people in poverty. Each of these strategies is fraught with significant issues of racial justice, and each carry challenges that could result in failure. But unless well-planned actions in all three strategies are implemented, we will not succeed.

   There is a growing body of research that describes poverty more comprehensively. The *Area Deprivation Index* and *Social Deprivation Index* are peer-reviewed approaches to measure poverty and its resulting implications within a given geography[23]. This is critical because these types of measures force us to think beyond poverty as an individual phenomenon and consider the geospatial organization of poverty and its implications for whole communities within our region.

   Poverty, especially racialized poverty in this region, has to be viewed through this lens to fully appreciate why it is so stubborn to engage. For example, a young person living in the northeast section of the City of Rochester known as the *Crescent*, a notably impoverished section of our community, is not just dealing with a lack of money but also reduced social capital to access opportunities including educational resources, mentors and employment opportunities. Structural racism makes it more likely that this is a young person of color and subject to many of the disparities described throughout this report. Simply getting this young person across the poverty threshold is not only improbable given the communitywide deprivation, but insufficient to create a thriving healthy community in which this child can grow and contribute.

3. Take immediate actions to lessen the **concentration of student poverty**. The process described above will take decades to achieve – our children cannot wait! Our region's concentration of poverty is even greater for children. The City of Rochester is home to 70% of Monroe County's poor children and 49% of the poor children in the nine-county region. The resulting concentration of student

poverty within the Rochester City School District is staggering and presents the District with educational challenges not even imagined in our suburban schools. There are certainly some strategies available, like the efforts of *Great Schools for All* to establish cross-district magnet schools and to provide learning based on successful practices in other regions[24]. It will require region-wide leadership and cooperation to bring these and other strategies into action.

4. Work to reverse the **de-concentration of employment**. For several decades, the City of Rochester was able to hold onto its employment base even as the population declined. But with the loss of manufacturing, with its anchoring brick and mortar plants, jobs have left the city.

   Earlier in this report we explored median household incomes by race, but it cannot be overlooked that total income in City of Rochester is approximately $4.3 billion while the Rochester region's total income is $34 billion. While the city is home to 17% of the region's population, it only accounts for 12.6% of the region's gross income.[25]

   What makes this disparity even more pernicious is the manner in which it is reinforced by the distribution of our workforce, in both the private and public sectors. Private sector employment frequently follows lower-cost land development options, often on the physical fringes of our area. Service sector jobs follow the more affluent population base. Economic development incentives have largely failed to bring jobs closer to the urban core.

   Even in the public sector, employment may be in the city, but income does not stay there. Take for example the Rochester City School District (RCSD), where its staff is overwhelmingly white and resides outside of the City of Rochester. The adopted 2020-2021 RCSD budget shows an actual 2018-2019 expense of $560,759,846 in salary, benefits, and compensation. Considering that over 70% of district staff reside outside of the City of Rochester, the implication is that approximately $400 million is flowing from the city to its surrounding suburbs. This same pattern is true across the uniformed municipal services (fire, police), capital construction (even when funded by the city), and many nonprofits. Suburbanites travel to the city to earn an income that is largely expended in the suburbs.

   Use of residency requirements and more targeted economic development incentives are tools to consider here.

5. Plan to **reduce residential segregation**. We have discussed the historical patterns of racial segregation. These patterns continue today. A 2012 study found that segregation in our area recorded the Rochester metro area as having the 5th highest degree of segregation among cities of Rochester's size[26]. Rochester's rating placed it 31% higher than the mid-point of comparably sized cities. This degree of segregation means that most in our area will have very little contact with people of other races.

   Reducing this segregation will take decades, but the value of desegregating at all levels of the income scale are undeniable.

On an individual level, people are likely to have many reactions to the data in this report: disbelief, confusion, anger; or maybe guilt. Of course, some will blame individuals for the fate of their group. While

individuals can, and do, behave in ways that contribute to their condition, to attribute that reality to an entire race or group of people is a racist idea. And it is an idea without any evidence.

Ibram Kendi posits the idea that a person can be a racist or an antiracist; that there is not a neutral middle ground of being "not racist." Kendi's definition of an antiracist is "one who is supporting antiracist policy through their actions or expressing an antiracist idea[27]." So, if one accepts Kendi's definitions, actions, or at least expressions of action, are required to avoid being racist.

So, what are actions that an individual can take? Here are a few:

- **Learn**: If you have read this report, your learning has begun. But there is so much more that we can learn – about disparities in other areas, such as adult health care and criminal justice. Or we can delve more deeply into the data presented here to understand how such inequalities came to be. To encourage further study, this report includes a learning kit (Appendix E) to help groups of various sizes move from awareness to a deeper understanding of the inequalities in our community.

- **Engage:** There are many ways to engage with others in our neighborhoods, churches, schools, places of work, clubs, and other social networks. Encouraging others in learning is a good way to engage. Engagement can also take place in one-on-one settings, such as using a data point in this report to start a conversation, or to counter unfounded statements that we sometimes hear. Another way to engage is to volunteer time and resources to organizations working to eliminate or alleviate the impacts of inequality.

- **Advocate:** Through political action or by joining in community movements, there are many ways to raise a voice against inequality.

- **Ask the hard questions.** This report makes it clear that conditions of inequality are greater in the Rochester region than elsewhere. While people are often generous with their time and money, we seldom hear calls for the kind of community change that is needed. We are outraged when there is racist graffiti in our neighborhood, but do we also advocate for inclusive zoning regulations in our town? Do we encourage affordable housing in our town?

We appreciate the time you took to read *Hard Facts 2020* and to consider its implications for our region. As you share this report, we encourage you to consider our suggestions for change and to think of other ways to make Rochester and the region more equitable for all. We suggest you share your ideas with your local representatives and community collaboratives referenced in this report.

ENDNOTES:

1. Rochester Area Community Foundation and ACT Rochester, *Poverty and the Concentration of Poverty in the Nine-County Greater Rochester Area*, December 13, 2013.

2. The nine-county region consists of Monroe, Wayne, Ontario, Seneca, Yates, Livingston, Genesee, Wyoming, and Orleans. These counties form the coverage area for ACT Rochester, as well as for other regional programs, such as the Finger Lakes Regional Economic Development Council.

3. The majority of indicators in this report are from the U.S Census Bureau's American Community Survey for 2014-18. This is the most recent data at the time of this report. The American Community Survey is a scientific series of ongoing surveys with the results published annually for a single year, or for a five-year weighted average. The five-year average is used here because it has the lowest margin of error. Data in the Educational Testing Outcomes section are from the NY State Department of Education for the 2019 school year. Two indicators: Low Birth Weight (Chart 1) and Infant Mortality Rate (Chart 2) are from the Monroe County Department of Public Health for 2017. These two indicators are for Monroe County only. All other indicators are for the nine-county Rochester region. All data used in Charts 1-36 is available on the ACT Rochester website (see #5 below).

4. Ibram X. Kendi, *How to Be an Antiracist*: New York: Random House, 2019

5. American Anthropological Association, *Race: Are We So Different?* (http://www.understandingrace.org/

6. ACT Rochester is a community indicators Initiative of Rochester Area Community Foundation. ACT Rochester's purpose "is to change the culture of community problem-solving and associated decision making through the use of credible, independent and timely data." The website (ACTRochester.org) tracks more than 100 indicators in nine program categories, as well as data for major community initiatives dealing with race and ethnicity, poverty, and education. Among the resources on the website is ACT Rochester's annual Community Report Card.

7. The federal poverty level income for 2020 is $12,760, plus an additional $4,480 for each additional family member. It is widely recognized that this level is well below what is needed to meet basic needs. For a detailed comparison and discussion of the difference between the poverty level and financial self-sufficiency, see: *Poverty and Self-Sufficiency in the Nine-County Greater Rochester Area*, ACT Rochester and Rochester Area Community Foundation, September 2016. (ACTRochester.org)

8. Common Ground, "Racism is a Public Health Crisis" CommonGroundHealth.org

9. Dolores Acevedo-Garcia, Clemens Noelke, Nancy McArdle, "The Geography of Child Opportunity: Why Neighborhoods Matter for Equity" Diversity Data Kids, Child Opportunity Index 2.0 http://www.diversitydatakids.org/sites/default/files/file/ddk_the-geography-of-child-opportunity_2020v2_0.pdf

10. The Rochester metro is the Census Bureau's Rochester Metropolitan Statistical Area (MSA). It consists of six of the nine counties in the region: Monroe, Livingston, Ontario, Orleans, Wayne, and Yates.

11. "The Geography of Child Opportunity," p. 25. http://www.diversitydatakids.org/sites/default/files/file/ddk_the-geography-of-child-opportunity_2020v2_0.pdf

12. The term "academic achievement" begs the question: whose achievement – the student, the schools, or the community? It certainly should not be viewed as a measure of achievement by the children, but often is.

13. The unemployment rate used here is from the U.S. Census Bureau's American Community Survey for 2014-18. On the survey, individuals who identify themselves as being in the workforce are asked if they experienced unemployment during the past 12 months. It is different from the point-in-time rate (from the Bureau of Labor Statistics) that is popularly used. The rate used here has certain advantages: it shows an individual's experience over the course of 12 full months (that is why it is higher than the point-in-time rate); and it is available by race and ethnicity. However, this is a lagging indicator and is less accurate at gauging the current status.

14. Brookings Institution, Metropolitan Policy Program. As reported in the Rochester Democrat and Chronicle, May 19, 2019.

15. Monroe County Department of Public Health, Monroe County COVID-19 Preliminary data as of July 2015 https://www2.monroecounty.gov/files/health/coronavirus/2020-07-15-COVID19%20Surveillance.pdf

16. Ernie Tedeschi and Quoctung Bui, "Unemployment Tracker: Job Losses for Black Workers are Deepening," New York Times, June 16, 2020.

17. ACT Rochester, *Hard Facts*, August 2017, p. 18 (Chart 24).

18. For a detailed description of how government caused or allowed overt housing segregation, see Richard Rothstein, *The Color of Law: A Forgotten History of How Our Government Segregated America*, New York: Liveright Publishing Corporation. For a Rochester perspective, see Justin Murphy, Closed Doors, Rochester Democrat and Chronicle, February 9, 2020.

19. Rochester Area Community Foundation and ACT Rochester, "Hard Facts," 2017, p.18, note # 5.

20. https://www.monroecounty.gov/news-2020-06-18-commission

21. "Confronting Racial Covenants: How they Segregated Monroe County and What to Do About Them," City Roots Community Land Trust and Environmental Protection Clinic at Yale University, July 2020.

22. Rochester Area Community Foundation and ACT Rochester, “Poverty and the Concentration of Poverty in the Nine-County Greater Rochester Area,” December 2013.

23. University of Wisconsin, Department of Medicine, About the Neighborhood Atlas https://www.neighborhoodatlas.medicine.wisc.edu; and Robert Graham Center, Social Deprivation Index www.graham-center.org/rgc/maps-data-tools/sdi/social-deprivation-index.html

24. Great Schools for All (GS4A) http://gs4a.org/

25. U.S. Census - American Community Survey for 2014-18.

26. Edward Glaeser and Jacob Vigdor “The End of the Segregated Century,” Manhattan Institute for Policy Research, Jan., 2012.

27. Kendi, p. 13.

Nine-County Region - Population by Race and Ethnicity						
County →	Monroe		Livingston		Genesee	
Race/Ethnic Group	**Number**	**%**	**Number**	**%**	**Number**	**%**
White	566,271	76.1%	59,696	93.4%	53,404	91.9%
African American	113,538	15.3%	1,805	2.8%	1,304	2.2%
American Indian[1]	3,378	0.4%	128	0.2%	510	0.9%
Asian	26,661	3.6%	833	1.3%	477	0.8%
Native Hawaiian[2]	120	*	22	*	0	0.0%
Some Other Race	12,226	1.6%	429	0.7%	997	1.7%
2 or More Races	22,054	3.0%	994	1.6%	1,420	2.5%
Total – All Races	744,248	100.0%	63,907	100.0%	58,112	100.0%
Latino[3]	63,631	8.5%	2,223	3.5%	1,849	3.2%

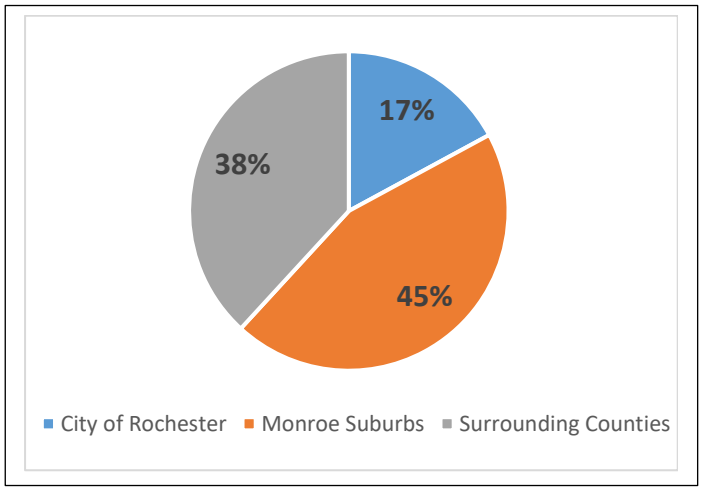
County →	Orleans		Wyoming		Wayne	
Race/Ethnic Group	**Number**	**%**	**Number**	**%**	**Number**	**%**
White	36,583	88.8%	37,162	91.6%	84,701	93.2%
African American	2,541	6.2%	1,837	4.5%	2,631	2.9%
American Indian[1]	151	0.4%	228	0.6%	144	0.1%
Asian	326	0.8%	155	0.4%	606	0.7%
Native Hawaiian[2]	21	0.1%	0	0.0%	78	0.1%
Some Other Race	802	1.9%	454	1.1%	786	0.9%
2 or More Races	751	1.8%	729	1.8%	1,910	2.1%
Total – All Races	41,175	100.0%	40,565	100.0%	90,856	100.0%
Latino[3]	1,961	4.8%	1,320	3.3%	3,878	4.3%

County →	Ontario		Seneca		Yates		Nine-County Total	
Race/Ethnic Group	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
White	101,467	92.7%	31,669	91.5%	24,061	96.2%	995,014	82.4%
African American	2,770	2.5%	1,707	4.9%	226	0.9%	128,359	10.6%
American Indian[1]	487	0.5%	135	0.4%	53	0.2%	5,214	0.4%
Asian	1,455	1.3%	242	0.7%	189	0.8%	30,944	2.6%
Native Hawaiian[2]	37	*	0	0.0%	7	*	285	*
Some Other Race	1,480	1.4%	234	0.7%	164	0.7%	17,572	1.5%
2 or More Races	1,776	1.6%	625	1.8%	309	1.2%	30,568	2.5%
Total – All Races	109,472	100.0%	34,612	100.0%	25,009	100.0%	1,207,956	100.0%
Latino[3]	5,058	4.6%	1,158	3.3%	549	2.2%	81,627	*6.8%*

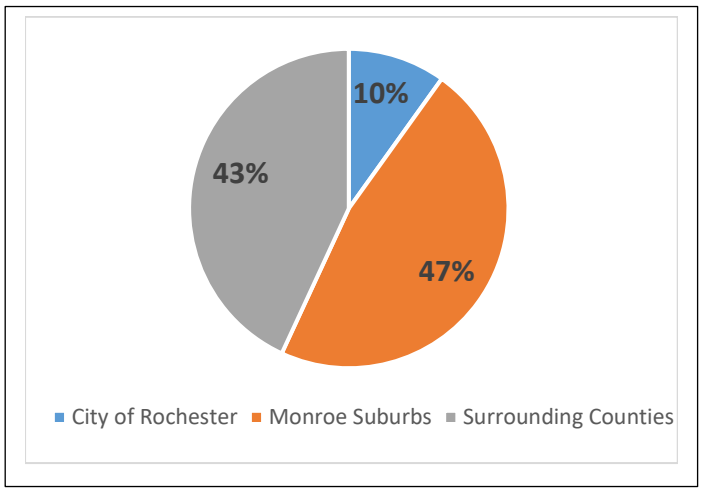
Source: U.S. Census, American Community Survey for 2014-18
1. American Indian and Alaska Native; 2. Native Hawaiian and Pacific Islander; Latinos of any race; * = less than .05 percent.

WHERE WE LIVE

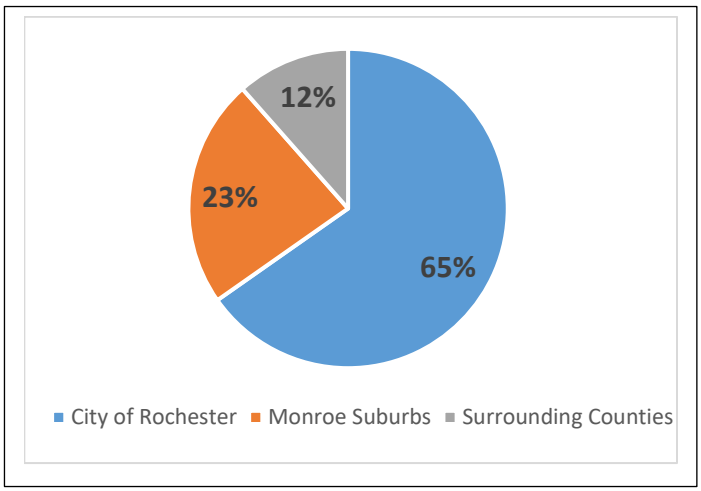
Total Population



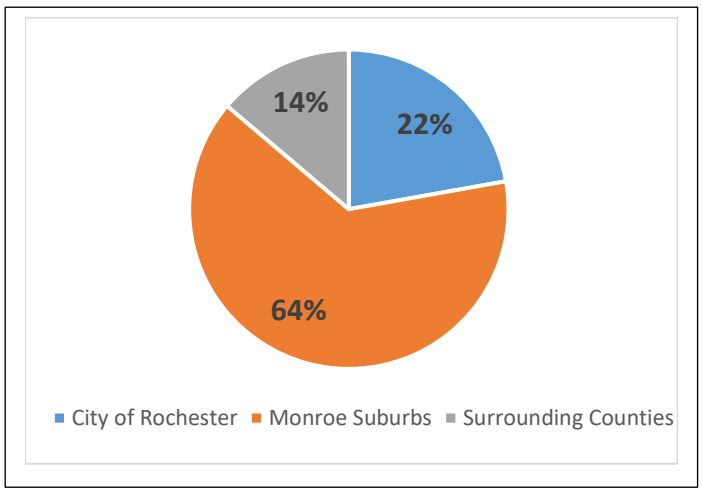
White Population



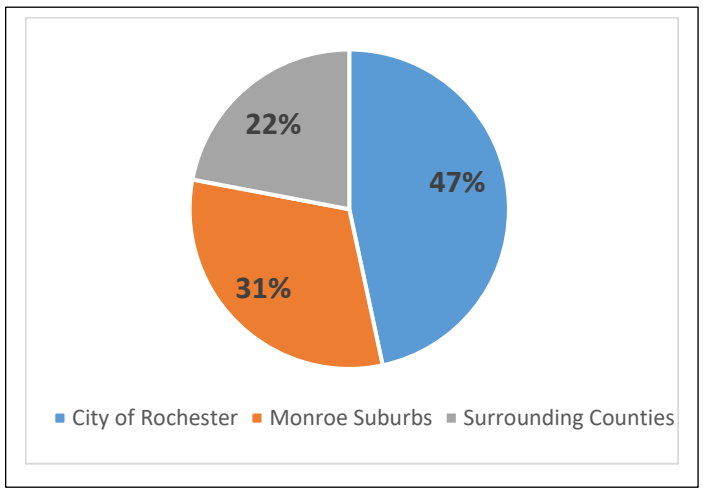
African American Population



Asian Population



Latino Population



Changes in the Racial and Ethnic Divide: 2017 *Hard Facts* Report and this 2020 *Hard Facts* Update
Disparities Within the Nine-County Rochester Region

	Gaps for African Americans				Gaps for Latinos		
Indicator	**Gap 2017 Report**	**Gap 2020 Update**	**Change In Gap**		**Gap 2017 Report**	**Gap 2020 Update**	**Change In Gap**
Low Birth Weight	2.3 times	2.5 times	**+**		1.5 times	2 times	**+**
Infant Mortality	2.8 times	3 times	**+**		1.2 times	2 times	**+**
Child Poverty	4.2 times	3.8 times	**-**		3.5 times	3.1 times	**-**
Grade 3 English	28%	48%	**- -**		40%	52%	**- -**
Grade 3 Math	NA	49%	NA		NA	54%	NA
Grade 8 English	28%	35%	**- -**		32%	42%	**- -**
Graduation Rate	73%	79%	**- -**		74%	82%	**- -**
Unemployment Rate	3 times	3 times	**unch.**		2.2 times	2.5 times	**+**
Median Income	48%	49%	**-**		53%	53%	**unch.**
Poverty Rate	3.3 times	3.4 times	**+**		3.1 times	3.2 times	**+**
Homeownership	45%	44%	**+**		48%	48%	**unch.**
% of Income for Rent	1.6 times	1.5 times	**-**		1.3 times	1.5 times	**+**
Home Values	NA	59%	NA		NA	68%	NA

Gaps are the difference in outcomes for African Americans and Whites or for Latinos and Whites. For deficit indicators (poverty, unemployment, etc.), gaps are expressed as the number of times the White outcome would be multiplied to equal the African American or Latino rate. For example, in 2020, the Infant Mortality Rate for African Americans is 3 times that of Whites. For asset indicators, the gap is expressed as a percent of the White outcome. Change in Gap: + means gap increased; - means gap decreased; - - means gap decreased significantly; unch. signifies that the gap is unchanged; NA = not available.

Changes in the Racial and Ethnic Disparities: 2017 *Hard Facts* Report and 2020 *Hard Facts* Update

Gaps for African Americans and Latinos in the Nine-County Rochester Region, Compared with African Americans and Latinos in the Nation or New York State

	Gaps for Regional **African Americans** Compared with the Nation or New York State (All comparisons are with African Americans in the U.S. as a whole, except education outcomes, which are compared with NY State as a whole)				Gaps for Regional **Latinos** Compared with the Nation or New York State (All comparisons are with Latinos in the U.S. as a whole, except education outcomes, which are compared with NY State as a whole)		
Indicator	**Gap 2017 Report**	**Gap 2020 Update**	**Change In Gap**		**Gap 2017 Report**	**Gap 2020 Update**	**Change In Gap**
Child Poverty	1.3 times	1.4 times	**+**		1.3 times	1.4 times	**+**
Grade 3 English	42%	56%	**- -**		63%	63%	**unch.**
Grade 3 Math	NA	65%	NA		NA	72%	NA
Grade 8 English	46%	46%	**unch.**		50%	51%	**-**
Graduation Rate	93%	96%	**- -**		94%	100%	**- -**
Unemployment Rate	1.2 times	1.3 times	**+**		1.3 times	1.6 times	**+**
Median Income	76%	75%	**+**		70 %	66%	**+**
Poverty Rate	1.3 times	1.4 times	**+**		1.4 times	1.5 times	**+**
Homeownership	79%	76%	**+**		76%	74%	**+**
% of Income for Rent	NA	1.3 times	NA		NA	1.4 times	NA
Home Values	NA	50%	NA		NA	46%	NA

Gaps are the difference in outcomes for African Americans or Latinos in the Nine-County Rochester region and African Americans or Latinos nationwide, except for the education. Education outcomes compare African Americans or Latinos to their counterparts in NY State. For deficit indicators (poverty, unemployment, etc.), gaps are expressed as the number of times the national (or NY State) outcome would be multiplied to equal the rate for the Nine-County Rochester region.
Change in Gap: + means gap increased; - means gap decreased; - - means gap decreased significantly; unch. signifies that the gap is unchanged; NA = not available.

Ideas and Resources to Expand Learning

Having read this report, you know that racial and ethnic inequalities shape the lives – from birth onward – of African Americans and Latinos. The magnitude of the disparities may be shocking and leave you asking, what can one person do to bring about change? We encourage you to discuss this report with your circle – with family, friends, religious groups, classmates, and co-workers – to more deeply understand how Rochester and many of its residents came to be in this situation.

This kit is intended to foster such learning. It is organized around three potential levels of learning, though of course, there are infinite levels of learning possible. The tips provided here are intended to help and encourage learning, but they are guidelines not firm rules.

Level 1: Expanding Awareness

Goal: To share the awareness gained from this report with a group of co-workers, a religious congregation, a high school or college class, a civic club, neighborhood organization, or any other group.

Resources: The report and a PowerPoint presentation summarizing the report may be downloaded from: ACTRochester.org

Size of Group: Any size

Approach: Using the PowerPoint presentation, the leader summarizes the report information (about 30 to 45 minutes) and then encourages a group discussion (15 to 45 minutes). [Note: the PowerPoint presentation includes probing questions to foster this discussion]

Requirements:

a. A leader/presenter who has read the report and is comfortable in leading a group learning;
b. A room large enough for the group, or a virtual meeting software (such as ZOOM);
c. A laptop computer and a PowerPoint projector (if these are not available, paper copies of the presentation can be used);
d. Time needed: 1 to 1 ½ hours is ideal; 45 minutes is minimum.

Level 2: Expanded Awareness, plus a Deeper Dive

Goal: The same as level one with the addition of small group discussion to delve more deeply into one (or more) of the broad topic areas of the report: Child Health and Well-being; Education; Economic Well-being; Housing.

Resources: The report and a PowerPoint presentation summarizing the report may be downloaded from: ACTRochester.org

Size of Group: Enough for small breakout groups and discussion (10 or 12 minimum; no maximum).

Approach: The same as level one, except that the general discussion after the presentation should be kept brief (about 10 minutes). Then the group should select a topic area by consensus (or this could be done in advance) and break into groups of 4 to 6. Each group would have the same task, to explore the root causes of the local disparities documented in the report. A group facilitator should be selected (by the group or in advance) to keep the discussion on-topic and to record the key points of discussion. After a 15-minute small group discussion, participants should reconvene, and the group facilitators report on the key points. If the group wishes to, the key points can be recorded for future discussion.

Requirements:

a. A leader/presenter who has read the report and is comfortable in leading a group learning;
b. Facilitators for each small group of about 4 to 6 people;
c. A room large enough for the group, or a virtual meeting software (such as ZOOM);
d. Space for small group discussion, or if using virtual software, the leader should be facile in the use of the break-out group functions;
e. A laptop computer and a PowerPoint projector (if these are not available, paper copies of the presentation can be used);
f. Flip charts and markers to record small group discussion (unless using virtual meeting software);
g. Time needed: About 1 ½ hours to 2 hours is ideal.

Level 3: Fostering an Antiracist Rochester

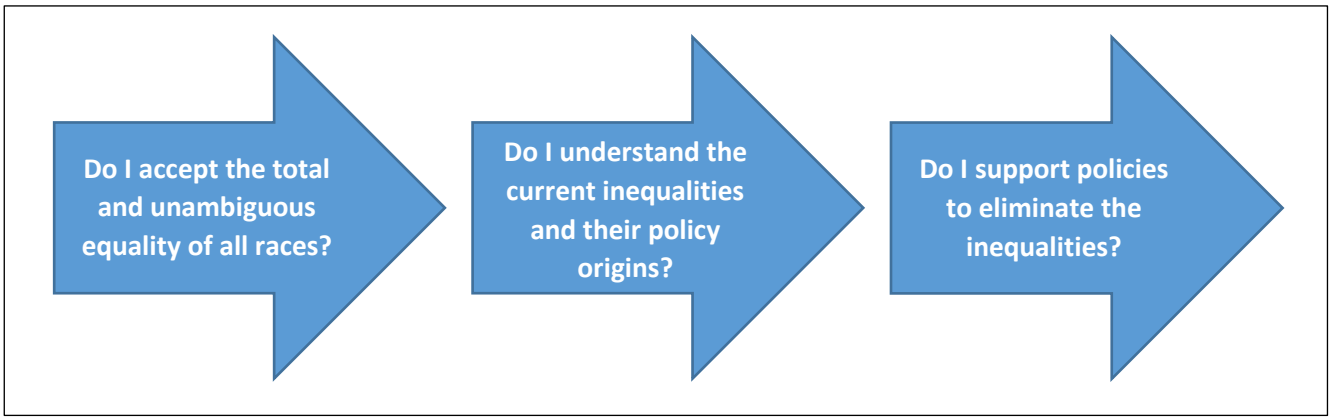
Goal: To use the findings of the *Hard Facts* report as a springboard to enlist a group of individuals in becoming community change agents based on antiracist concepts, using Ibram Kendi's definition of an antiracist as: "one who is supporting an antiracist policy through their actions or expressing an antiracist idea."

Resources:

a. The report and a PowerPoint presentation summarizing the report may be downloaded from: ACTRochester.org
b. Ibram X. Kendi's *How To Be An Antiracist*: New York: Random House, 2019
c. Other reading material as determined by the group.

Size of Group: The size is not important, but a small group dedicated to a deeper learning is a good place to start.

Approach: Each group should design an approach for itself. It is suggested that each group member read the *Hard Facts 2020* report and Kendi's book. A key to the antiracist concept is that the racial inequalities that we observe (and document) are the result of policies and practices, not the actions of individuals. So, to be an antiracist requires us to see the policy origins of an observed inequality and identify policy approaches to correct them. For example, the value of homes owned by African Americans in our region is equal to only 59% of those owned by Whites (see chart 33). Do we understand the policies that have contributed to this? Can we find advocate policy remedies? The graphic below illustrates this process.



One approach to this would be to have one or two general learning sessions followed by 3 to 5 sessions focused on "unpacking" the inequalities described in *Hard Facts 2020*. Participants might agree to do further reading in preparation for each topic discussion.

Requirements: The main requirement here is for individuals to be committed to the antiracist concept and to be willing to study the inequalities in our community. The group might want to share its work with a broader network. A good leader will be needed.

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ACTRochester.org

Racial and Ethnic Disparities in the Greater Rochester Region

Genesee, Livingston, Monroe, Ontario, Orleans, Seneca, Wayne, Wyoming and Yates counties

Indicator	White	Black or African American	Hispanic or Latino	Asian	Source Notes
Infant mortality: number of infant deaths prior to age one for each 1,000 live births					
Total rate per group - Monroe County	5	15	10	NA	1
Rate as a percent of White	NA	+300%	+200%	NA	

Children in Poverty: percent of children age 18 or younger living below federal poverty level					
Percent per group - US	16%	35%	28%	11%	2
Percentage point difference from White	NA	+19 pts	+12 pts	-5 pts	
Percent per group - NYS	13%	30%	24%	18%	2
Percentage point difference from White	NA	+17 pts	+21 pts	+5 pts	
Percent per group - region	13%	49%	40%	13%	2
Percentage point difference from White	NA	+36 pts	+27 pts	0 pts	
Percent per group - Monroe County	12%	50%	42%	13%	2
Percentage point difference from White	NA	+38 pts	+30pts	+6 pts	
Percent per group - Rochester	43%	56%	55%	32%	2
Percentage point difference from White	NA	+13 pts	+12 pts	-11 pts	

1. ACT Rochester – Children and Youth – Infant mortality rate by race/ethnicity for Monroe County, Monroe County Department of Public Health, 2015-2017.

2. ACT Rochester – Children and Youth – Children in Poverty by race/ethnicity, US Census American Communities Survey, data averaged for 2014 to 2018.

05/27/2020

Indicator	White	Black or African American	Hispanic or Latino	Asian	Source Notes
Student Performance: 3rd Grade Reading: Percent "passing' [see note] NY State exam					
Percent passing per group - NYS	58%	45%	43%	71%	3
Percentage point difference from White	NA	-13 pts	- 15pts	+13 pts	
Percent passing per group - our region	52%	25%	27%	53%	3
Percentage point difference from White	NA	-27 pts	-25 pts	+1 pts	
Percent passing per group - Monroe County	58%	25%	28%	52%	3
Percentage point difference from White	NA	-33 pts	-30 pts	-6 pts	
Percent passing per group - Rochester	34%	18%	14%	23%	3
Percentage point difference from White	NA	-16 pts	-20 pts	-11 pts	
Student Performance: 3rd Grade Math: Percent "passing' [see note] NY State exam					
Percent passing per group - NYS	62%	43%	43%	77%	4
Percentage point difference from White	NA	-19 pts	-19 pts	+15 pts	
Percent passing per group - our region	57%	28%	31%	63%	4
Percentage point difference from White	NA	-29 pts	-26 pts	+6 pts	
Percent passing per group - Monroe County	63%	28%	32%	63%	4
Percentage point difference from White	NA	-35 pts	-31 pts	0 pts	
Percent passing per group - Rochester	38%	20%	22%	28%	4
Percentage point difference from White	NA	-18 pts	-16 pts	-10 pts	

3. ACT Rochester – Education – Student Performance on Grade 3 English by race/ethnicity, NY State Department of Education, 2019. Note: "passing" is defined as students achieving level 3 or higher on standardized exams.

4. ACT Rochester – Education – Student Performance on Grade 4 Math by race/ethnicity, NY State Department of Education, 2019. Note: "passing" is defined as students achieving level 3 or higher on standardized exams.

Indicator	White	Black or African American	Hispanic or Latino	Asian	Source Notes
Student Performance: 8th Grade English: Percent "passing' [see note] NY State exam					
Percent passing per group - NYS	53%	37%	39%	70%	5
Percentage point difference from White	NA	-16 pts	-14 pts	+17 pts	
Percent passing per group - our region	48%	17%	20%	55%	5
Percentage point difference from White	NA	-31 pts	-28 pts	+7 pts	
Percent passing per group - Monroe County	52%	16%	19%	55%	5
Percentage point difference from White	NA	-33 pts	-33 pts	+3 pts	
Percent passing per group - Rochester	24%	9%	9%	10%	5
Percentage point difference from White	NA	-15 pts	-15 pts	-14 pts	

Graduation Rate: High School Cohort Graduation Rate					
Rate per group - NYS	90%	75%	75%	90%	6
Percentage point difference from White	NA	-14 pts	-14pts	0 pts	
Rate per group - our region	91%	72%	75%	92%	6
Percentage point difference from White	NA	-19 pts	-16 pts	+1 pt	
Rate per group - Monroe County	92%	71%	74%	92%	6
Percentage point difference from White	NA	-21 pts	-18 pts	0 pts	
Rate per group - Rochester	64%	63%	63%	76%	6
Percentage point difference from White	NA	-1 pt	-1 pt	+12 pts	

5. ACT Rochester – Education – Student Performance on Grade 8 English by race/ethnicity, NY State Department of Education, 2019. Note: "passing" is defined as students achieving level 3 or higher on standardized exams.

6. ACT Rochester – Education - The number of students graduating on time (after four years of high school), as a percentage of their cohort. The cohort is the class of ninth graders beginning high school together from 2016-2019.

Indicator	White	Black or African American	Hispanic or Latino	Asian	Source Notes
Education Attainment: Percent of population 25 or older with four-year degrees					
Percent per group - US	33%	21%	16%	53%	7
Percentage point difference from White	NA	-12 pts	-17 pts	+22 pts	
Percent per group - NYS	40%	24%	19%	47%	7
Percentage point difference from White	NA	-16 pts	-21 pts	+7 pts	
Percent per group - our region	35%	13%	16%	52%	7
Percentage point difference from White	NA	-22 pts	-19 pts	+17 pts	
Percent per group - Monroe County	42%	14%	16%	53%	7
Percentage point difference from White	NA	-28 pts	-26 pts	+14 pts	
Percent per group - Rochester	36%	10%	9%	35%	7
Percentage point difference from White	NA	-26 pts	-27 pts	-1 pt	

Housing: Home ownership rates: Percent of owner-occupied housing units					
Percent per group - US	69%	42%	47%	59%	8
Percentage point difference from White	NA	-27 pts	-22 pts	-10 pts	
Percent per group - NYS	64%	31%	25%	48%	8
Percentage point difference from White	NA	-37 pts	-39 pts	-16 pts	
Percent per group - our region	73%	35%	32%	55%	8
Percentage point difference from White	NA	-38 pts	-41 pts	-18 pts	
Percent per group - Monroe County	71%	32%	34%	53%	8
Percentage point difference from White	NA	-39 pts	-37 pts	-18 pts	
Percent per group - Rochester	43%	28%	27%	27%	8
Percentage point difference from White	NA	-19 pts	-16 pts	-16 pts	

7. ACT Rochester – Education – Education Attainment by race/ethnicity, US Census American Communities Survey, data averaged for 2014-2018.

8. ACT Rochester – Housing – Home Ownership Rate by race/ethnicity, US Census American Communities Survey, data averaged for 2014-2018.

Indicator	White	Black or African American	Hispanic or Latino	Asian	Source Notes
Housing Affordability: percent of annual income spent on rent					
Percent per group - US	28%	35%	32%	27%	9
Percentage point difference from White	NA	+7 pts	+4 pts	-1 pt	
Percent per group - NYS	30%	35%	37%	36%	9
Percentage point difference from White	NA	+5 pts	+7 pts	+6 pts	
Percent per group - Monroe County	30%	45%	44%	30%	9
Percentage point difference from White	NA	+15 pts	+14 pts	0 pts	
Percent per group - Rochester	33%	47%	51%	31%	9
Percentage point difference from White	NA	+14 pts	+18 pts	-2 pts	
Median household income: US Census median income					
Annual income per group - US	$63,917	$40,156	$49,225	$83,898	10
Income as percent of White	NA	63%	77%	131%	
Annual income per group - NYS	$73,584	$46,178	$46,259	$72,131	10
Percentage point difference from White	NA	63%	63%	98%	
Annual income per group - our region	$61,627	$30,182	$32,606	$63,918	10
Income as a percent of White	NA	49%	53%	104%	
Annual income per group - Monroe County	$64,468	$30,034	$31,331	$62,159	10
Percentage point difference from White	NA	47%	49%	96%	
Annual income per group - Rochester	$41,262	$26,038	$23,497	$34,850	10
Percentage point difference from White	NA	63%	57%	84%	

9. ACT Rochester – Housing – Affordable Housing: Median Gross Rent by race/ethnicity, US Census American Communities Survey, data averaged for 2014 to 2018.

10. ACT Rochester – Financial Self Sufficiency – Median Household Income by race/ethnicity, US Census American Communities Survey, data averaged for 2014 to 2018 and stated in 2018 dollars.

Indicator	White	Black or African American	Hispanic or Latino	Asian	Source Notes
Economy: Unemployment Rate					
Percent per group - US	4.9%	10.6%	6.8%	4.6%	11
Percentage point difference from White	NA	+5.7 pts	+1.9 pts	-0.3 pts	
Percent per group - NYS	4.8%	10%	7.8%	4.9%	11
Percentage point difference from White	NA	+5.2 pts	+3 pts	+0.1 pts	
Percent per group - our region	4.4%	13.8%	10.8%	3.9.%	11
Percentage point difference from White	NA	+9.4 pts	+6.4pts	-0.5pts	
Percent per group - Monroe County	4.4%	14.1%	11%	4.1%	11
Percentage point difference from White	NA	+9.7 pts	+6.6 pts	-0.3 pts	
Percent per group - Rochester	6.7%	17.5%	15.7%	6.7%	11
Percentage point difference from White	NA	+10.8 pts	+9.0 pts	0 pts	

11. ACT Rochester – Economy – Unemployment Rate by race/ethnicity, US Census American Communities Survey, data averaged for 2014 to 2018.

Tips for Discussing Racial Injustice in the Workplace

In recent years, psychologists have done significant research on the impact of systemic racism. Specifically, researchers including Wong et al. (2014) and Bilotta et al. (2019) have explored two kinds of systemic racism—*overt* and *aversive*.

Overt racism is the type exhibited directly in the form of racial slurs, castigation of others and explicit bias against a racial group. Aversive racism is typically performed by "well-meaning" individuals who have an espoused aversion to being perceived as racist, while nonetheless acting with bias. Aversive racist behaviors typically manifest as *microaggressions*, a term coined by Pierce in 1970.

Microaggression refers to brief and commonplace daily verbal, behavioral or environmental indignities, intentional or unintentional, that communicate hostile, derogatory or negative prejudicial slights and insults toward any group, particularly the culturally marginalized or a racial minority. A microaggression, as defined by Merriam-Webster, is a comment or action that subtly, and often unconsciously or unintentionally, expresses a prejudiced attitude toward a member of a marginalized group.

The American Psychological Association and researchers such as Sue et al. (2007) recognize three forms of microaggressions:

1. Microassaults: Conscious and intentional actions or slurs. *Examples:* using racial epithets; displaying swastikas; in a restaurant, deliberately serving white diners before black diners.

2. Microinsults: Verbal and nonverbal communications that subtly convey rudeness and insensitivity, thereby demeaning a person's racial heritage or identity. *Examples:* an employee of color is repeatedly asked how she got her job, with the implication it was through an affirmative action or quota system and not on her own merits; a Latino male speaking fluent English is addressed as "señor" by a non-Spanish speaker.

3. Microinvalidations: Communications that subtly exclude, negate or nullify the thoughts, feelings or experiential reality of the target person. *Example:* Asian-Americans are asked where they are "from," implying that they are perpetual foreigners in their own land.

When microaggressions are coupled with consistent overt racism, including physical assaults (as seen with the murders of George Floyd, Breonna Taylor and many others), it becomes absolutely

Tips for Discussing Racial Injustice in the Workplace

critical for Americans—including employers—to have an open and honest conversation about race. For too long, authority figures have exhorted individuals and groups to avoid conflict, but *conflict avoidance* (DeChurch et al., 2002) merely subjugates the issues and further intensifies entrenched thinking. It is time to begin and maintain effective dialogue on racism using the best tools available.

What are some key pointers from the psychological literature for engaging in honest, open discussion? Here are five techniques and recommendations:

1. Communicate with a modified SBAR tool.

SBAR stands for *Situation, Background, Assessment and Recommendation*. This model for ensuring effective communication among disagreeing parties was first developed by the military and later adopted in health care settings. If two officers aboard a submarine, for example, are having a philosophical disagreement about how orders should be executed, each would provide an SBAR and work collaboratively to make a joint recommendation. In the case of parties who disagree over an issue involving race, the SBAR tool might be reframed as Situation, Background, Acknowledgment and *Rebuilding*. Both sides would share their backgrounds and acknowledge the other's perspective (without comparing it to their own—see #3 below), enabling them to reimagine the situation and *rebuild* a new way to move forward. Success may not be possible, but they will have made an earnest effort.

2. Communicate with a modified DESC tool.

DESC stands for *Describe, Express, Specify and Consequences*, a communications model introduced in Asserting Yourself: A Practical Guide for Positive Change (Bower, 1976) and used by marriage counselors in the 1990s (DESC Script for Assertiveness). In the early 2000s (AHRQ, 2005), researchers pioneered the technique to help eliminate medical team members' ingrained biases; specifically, nurses were taught to use the DESC Script with abusive physicians in an effort to develop a more assertive and authoritative tone.

In the case of racism in the workplace, employers seeking honest communication should use a modified DESC Script, allowing the parties to Describe, Express and Specify the nature of the

racism encountered and *Collaborate* on a solution. Because racism is completely unacceptable from any party going into such a discussion, *Consequences* are less important than collaboration toward a solution.

3. Don't conflate, compare or contrast.

Human brains are wired to process information by finding similarities and differences; we intuitively compare and contrast everything imaginable. When someone aggrieved by overt or aversive racism describes their experiences, listeners have a natural tendency to be defensive or to try to identify parallels with their own experiences. This is conflation, the biggest mistake made by most parties guilty of inadvertent racism or microaggression. Don't do it. Listen to others with an open mind; hear their story without injecting yourself into it. Take it all in and learn. Most of us have not lived through mass genocide, so we cannot draw legitimate parallels between our lives and those of its survivors, nor pretend to understand how they feel about it. This is why slogans like "All Lives Matter" are offensive to black individuals who have endured racism for 450 years, and why comparisons of various events to the Holocaust are offensive to Jews.

4. Discuss, don't debate.

When driving open and honest dialogue, HR professionals and people managers should emphasize that the purpose of getting together is discussion, not debate or disagreement. Set up discussion rules. Articulate that the point of the conversation is to chart a course for future actions to eliminate racism from the workplace. Sometimes, discussing matters too deeply can result in feelings of indignation and invalidation. This is not acceptable. Listen to people's varying perspectives and find ways to shape future actions. Debating past perceptions of particular details will only result in failure.

Tips for Discussing Racial Injustice in the Workplace

5. Set goals and honor feedback.

People managers and HR professionals are encouraged to treat open discussions of racism the way they would discussions of job performance. Avoid blame or attribution and focus on behaviors. Define a challenging yet attainable measurable goal or objective to which all parties must ascribe and for which failure to do so is equivalent to a resignation. Consistent measurement is key, as with all other feedback. Psychologists have argued for the use of goal-setting theory in social instances for years; in today's climate, HR thought leaders speak to the notion of setting a goal to eradicate bias and racism. The goal should be a zero tolerance for racism, injustice and bias in the workplace.

Alexander Alonso, Ph.D., SHRM-SCP, is chief knowledge officer for SHRM.

https://www.shrm.org/resourcesandtools/hr-topics/behavioral-competencies/global-and-cultural-effectiveness/pages/tips-for-discussing-racial-injustice-in-the-workplace.aspx

Greater Rochester Black Agenda Group

DECLARATION: "RACISM IS A PUBLIC HEALTH CRISIS" | May 19, 2020

We agree that Racism is a Public Health Crisis and commit to taking urgent action because:

- Race is a social construct with no biological basis.

- Racism is a system that creates structures of opportunity and assigns value based on the social interpretation of how one looks, that unfairly disadvantages some individuals and communities, while unfairly providing advantages to other individuals and communities, and saps the strength of the whole society through the waste of human resources.

- Racism causes persistent racial discrimination in housing, education, health care, employment, criminal justice, business, and economic mobility. There is an emerging body of research that demonstrates racism as a social determinant of health.

- Racial health disparities in the Black Community have existed since racial health data has been collected and analyzed. Racial health disparities in diabetes, hypertension, heart disease, and mental health are prevalent and growing.

- Moreover, in Rochester and Monroe County, the persistent toxic stress of racism expressed as racial and ethnic discrimination impacts health through a combination of social-emotional and physiological effects. Researchers have found higher levels of stress hormones (allostatic loads) as an indicator of premature aging and death. [1]

- Of all the ways racial health disparities impact our life course and trajectory (path) the most profound is in Infant Mortality. African American babies in Monroe County die at 3-4 times the rate of white babies. This is a statistic that has not changed in many years and is trending in the wrong direction. [2]

- Public health's responsibilities to address racism include reshaping our discourse and agenda so that we all actively engage in anti-racist and racial justice work.

- While there is no epidemiological definition of "crisis", the health impact of racism clearly rises to the definition proposed by Galea: "The problem must affect large numbers of people, it must threaten health over the long-term, and it must require the adoption of large scale solutions."

- *"No one is born racist; it is modeled, learned, and passed along through generations where it poisons and paralyzes its victims and corrupts its perpetrators. If we are to eradicate this persistent evil we must see to its structural and institutional roots. And with swift and collective action hold those that govern and that are governed accountable for its elimination."*
  - Dr. Joy DeGruy

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[1] McEwen, C., McEwen, B. Social Structure, Adversity, Toxic Stress, and Intergenerational Poverty: An Early Childhood Model. Annu Rev Sociol. 2017; 43: 445-472.

[2] Vital Records data NYSDOH, Analyzed by MCDPH, 2014-2016

How can we avoid "blaming the victim" when we present information on poor outcomes for different racial, ethnic, language or immigrant groups in our community?

Groups working to eliminate or reduce differences (often called disparities) in how racial/ethnic groups fare compared to other racial/ethnic groups on important outcomes (education, wealth accumulation, health, etc.) need to report the differences to make their case for change and to track the progress of their work. For example, they may need to show the different rates of graduation from high school for white, African-American, Latino/a, Asian and Native American students (and they may also need to show differences in rates of graduation within these groups as well – by school, gender, language primarily spoken in the home, etc.) Groups use these kinds of data to raise awareness and concern, mobilize supporters, call officials and institutions to account and, to provide baseline (starting) and follow-up information for evaluation.

In addition to the difficulties in finding accurate and comparable information about outcomes for different racial/ethnic groups, there is another major challenge. This is the challenge of making sure people who view the data understand your group's analysis of why these differences exist in your community and how they might be corrected. The reason this is so important is that, without a context for viewing the data, people will create their own explanations. And people without an understanding of the cumulative effects of institutional and structural racism will tend to look for individual, rather than institutional or structural, explanations that end up "blaming the victim" for poor group outcomes.

"Blaming the victim" is the phenomenon of people seeing persistent and large group differences as being solely the result of attitudes, actions and inherent abilities of the individuals in the group or of a group "culture" and discounting or ignoring the role of government policies (like redlining), mechanics of resource allocation (like basing school resources on local property taxes), intergenerational opportunities for wealth accumulation (linked to educational opportunity) and cultural norms that reinforce disparate outcomes by race/ethnicity (national ideas such as meritocracy and individuality).

- For example, lower graduation rates for black and Hispanic teenagers compared to their white counterparts could be seen as a failure on the part of the school system to meet the educational needs of all students. They could also be seen as low interest in school by certain groups of students.

- The lack of Hispanic-owned businesses in predominantly Hispanic neighborhoods (or in the community as a whole) could be interpreted as evidence of institutional lending policies that do not take into account the commitment of "free" family labor as an asset. They could also be viewed as evidence of a low value placed on entrepreneurship in the Hispanic culture.

When presenting data that demonstrate differences in outcomes among groups, particularly those that illustrate poor outcomes (such as school dropout rates or business failure rates), it is important to put this information into context. Specifically, it is helpful to provide data supporting an understanding of differences as a result of policies, practices and decisions that are the target for change – consistent with your group's understanding.

- For example, high school graduation rate data could be accompanied by information on the number and percent of black and Hispanic teachers, particularly in the upper grades, and on the availability (or lack) of opportunities for students to pursue their studies on an alternative schedules that accommodates work

- Information on small business start-ups and failures for Hispanic-owned enterprises could be accompanied by summaries of the policies of lending organizations on how potential assets and costs are considered in making loans

It can be important to "'test-market" your presentation of data (report cards, evaluation reports, summary data tables, etc.) to understand the conclusions that key audiences are likely to draw from the data, from how different data are displayed or grouped on a page (for example, showing rates of graduation by school and resource allocation to schools on the same page) and from the surrounding text.

To be most effective, you need to test your materials with people who are likely to think like you and people who are likely to think very differently. Focus groups, one on one interviews, sharing materials and talking about them at various group meetings around town and even informal conversations with neighbors and co-workers can be very helpful.

Those whose experiences are reflected in the data – members of different racial, ethnic, language and cultural groups – need to be involved in developing ways to present information in respectful ways, ways that provide evidence of how disparities may have come about in your community and that highlight solutions addressing the underlying factors producing these differences.

Finger Lakes Regional Planning Consortium

Future of Telehealth Workgroup Summary

June 19, 2020 – 26 Attendees **August 25 – 36 Attendees**

Identified, Discussed, and Ranked Key Factors in Telehealth

Key Takeaways:

- Everyone, clients and providers, wants the telephonic mode of telehealth to be retained and the State is working to make that happen – has significantly addressed access issues caused by lack of transportation and/or broadband resources
- This valuable modality will only be sustainable with the continuation of viable rates – there is intense concern that, post-COVID, rates may be reduced to an unsustainable level.
- Continuation of the flexible permitted time intervals will be important – practice may evolve to more frequent, but shorter, contacts with clients – has increased engagement
- Request for State to be deliberate in moving toward uniformity in regulations across MA agencies
- While the telephonic mode is extremely valuable, there are some clients and circumstances in which it is not always the best modality:

  New Clients, in some cases
  Some Youth
  Clients with Substance Abuse disorders
  Assessments of Risk for Harm
  Situations where abuse is a concern - child, family, or partner
  Presentations where visual observation is needed or preferable

Highest Ranked TH Factors in Survey (for Importance and Regional Work Viability)

Client Satisfaction
Retention of Telephonic Modality
Development of Clinical Guidelines – Indications, Contraindications, Best Practices
Workforce Ramifications
Rates, Permitted Time Intervals & Frequency of Visits

Factor Selected & Referred to Clinical Integration Workgroup

Development of Clinical Guidelines

Indications, Contraindications, Best Practices
Permitted Time Intervals & Frequency of Visits w/Viable Rates

Questions? *Contact Beth White, RPC Coordinator at bw@clmhd.org or 518-391-8231*

Rochester Regional Health Telehealth Overview

Mandy Teeter presented RRH's framework for reviewing and understanding the impact of the rapid transition to telehealth delivery of services. Very informative – full presentation attached to meeting materials.

- They identified "buckets" of activity to review and address
- Documented decisions made and why all along the way – especially useful when looking back at transition
- Determined how to use clinical supervision to support staff's transition to and ongoing use of TH
- Develop checklist and did walk-throughs with staff re physical environment
- Regarding clinical guidelines – how to mitigate risk and balance that against potential COVID exposure
- Discovered that some TH platforms are better than others – want to narrow down the platforms used
- 60-70% of visits still TH at present
- Documented "meaningful contacts" that fell outside of the minimum billable times allowed. Has data on this that she will share with group.
- Found that TH increased visit completion rates by approximately 10%
- The ability to deliver multiple billable visits in same day helped increase engagement, as did the ability to deliver more frequent, shorter visits.

Ensuring Sustained Access to Telehealth in the Post-Pandemic Period

Jointly developed by the New York State Council for Community Behavioral Healthcare and the Community Health Care Association of New York State

This Report Included in Meeting Materials: Thanks to Sally Partner for sharing this

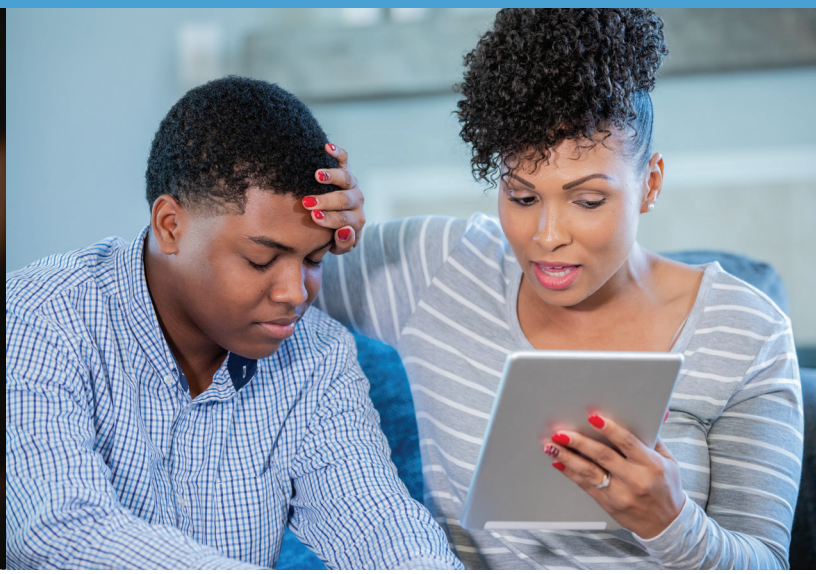
It's a good summary and echoes our main priorities

Next Steps: Convene Clinical Integration and Practice Workgroup to begin developing Clinical Guidelines for Telehealth

Full Survey Ranking Results - Telehealth Factors to Consider

SCORE	Q4: TELEMEDICINE FACTOR - MOST IMPORTANT
10.5	Retention of Telephonic Modality vs. only Audiovisual
9.75	Client Satisfaction
8.75	Rates
8.17	Uniformity of Regulations (DOH, OMH, OASAS, OCFS, OPWDD)
7.91	Workforce Ramifications - Staff Satisfaction with Remote Work
7.83	Permitted Time Intervals & Frequencies of Visits
7.36	Development of Clinical Guidelines - Indications, Contraindications, Best Practices
6.42	Parity - Behavioral Health versus Medical
6.36	Continuation of Current Expansion of Staff Titles able to Practice via Telemedicine
5.82	Tech Resource Issues - Internet Access, Initial issue was laptops & related tech, access to phones and plan minutes for clients
5.08	Parity - Commercial versus Medicaid
4.83	HIPAA Compliance
3.55	Staging/Phases of changes to current telehealth "permissions"

SCORE	Q5: TELEMEDICINE FACTOR - WHAT CAN WE WORK ON
10.75	Client Satisfaction
9.73	Retention of Telephonic Modality vs. only Audiovisual
8.36	Development of Clinical Guidelines - Indications, Contraindications, Best Practices
8.09	Workforce Ramifications - Staff Satisfaction with Remote Work
8	Rates Permitted Time Intervals & Frequencies of Visits
7.5	Tech Resource Issues - Internet Access, Initial issue was laptops & related tech, access to phones and plan minutes for clients
7.27	Uniformity of Regulations (DOH, OMH, OASAS, OCFS, OPWDD)
6.7	Desirability of current expansion of titles able to practice via telemedicine
6.4	Parity - Commercial versus Medicaid
5	Parity - Behavioral Health versus Medical
5	HIPAA Compliance
4.5	Staging/Phases of changes to current telehealth "permissions"



Ensuring Sustained Access to Telehealth in the Post-Pandemic Period

Jointly developed by the New York State Council for Community Behavioral Healthcare and the Community Health Care Association of New York State

NYS Council for Community Behavioral Healthcare

CHCANYS
Community Health Care Association of New York State

EXECUTIVE SUMMARY

Prior to the COVID-19 pandemic, poor reimbursement, complex regulatory structures, rigorous technology requirements, and limits on who could provide telehealth visits to which patients under what conditions led to modest telehealth penetration into safety net service delivery, including among behavioral health organizations and federally qualified health centers (FQHCs).Telehealth has shown great potential in expanding and ensuring access to behavioral health and primary care. In rural communities where there is no public transportation and the Medicaid cab system is dysfunctional, lack of transportation continues to be a barrier to accessing face-to-face treatment. Urban areas also face transportation challenges and a reluctance to utilize public transportation will likely outlast the public health emergency. Throughout the State, child-care and work-related difficulties also create barriers to accessing consistent mental health and primary care services. These types of barriers delay care and increase costs to the Medicaid system, because patients' symptoms may worsen to the point where hospital-based services are needed.

When COVID-19 struck New York and Governor Cuomo put the State on Pause, the benefit of telehealth options became quite clear. State regulators quickly offered flexibility. Telehealth treatment modalities that were once prohibited were suddenly encouraged. Technology requirements were waived, allowing both telephonic (audio only) and audio/visual visits. Provider types authorized to provide telehealth were expanded and reimburse ment became largely aligned with payments for face-to-face visits.

These reimbursement and regulatory changes, coupled with need to innovate in order to ensure patient access, led to a dramatic increase in tele-health utilization among safety net providers. For some consumers, telehealth – including telephonic care – became a lifeline while they sheltered in place. For some providers, telehealth became a financial lifeline, as revenues associated with in-person services cratered. However, an over-reliance on a heavily regulated telehealth system could exacerbate health inequities by making access to broadband, cell service, privacy, and technical capability new social drivers of health. In fact, in both rural and urban areas, unless access to broadband and technology is made universally accessible, the expansion of telehealth will further exacerbate health disparities based upon race, class, and other social factors.

The New York State Council for Community Behavioral Healthcare (NYSCCBH) and the Community Health Care Association of New York State (CHCANYS) have come together to develop recommendations for policymakers. We know that the people our individual members serve have historically struggled with access to services. Our patients live in communities plagued by poverty and structural racism that exacerbate health disparities. Together, we recognize that telehealth is a critical tool for improving care access and continuity. However, the sustained value of telehealth in improving access, care consistency, outcomes, and consumer satisfaction will depend on the post-pandemic regulatory and reimbursement environment.

To ensure that telehealth remains a valuable resource for people served by the safety net, we recommend that the State adheres to a set of core principles for determining telehealth regulatory and reimbursement structures:

1. Utilize telehealth to increase access and promote health equity through support for the full range of telehealth modalities.
2. Maximize regulatory flexibilities to sustain telehealth adoption.
3. Clinicians, in collaboration with clients, determine when a telehealth visit is appropriate.
4. Reimburse telehealth visits on par with in-person visits to ensure comprehensive, coordinated and integrated continuum of care.

INTRODUCTION

Prior to the novel coronavirus pandemic (COVID-19), telehealth in New York State was sparsely utilized. Nationally, only 10% of patients reported they had received care via telehealth in the past year[1] and 18% of physicians reported using the modality in 2018.[2] However, when Governor Cuomo put New York on Pause to mitigate the spread of COVID-19, State policymakers provided new flexibilities to expand telehealth. This resulted in an increased use among providers and enhanced access to care for patients at home. Because of the flexibility afforded to safety net providers, such as federally qualified health centers (FQHCs) and behavioral health organizations, many of the most vulnerable New Yorkers were able to maintain contact with their service providers throughout the pandemic.

In early March, recommendations put forth by the Centers for Disease Control and Prevention and Governor Cuomo encouraged individuals to stay home, resulting in a rapid and severe decrease of in-person visits at FQHCs and behavioral health organizations. However, patients still required primary care and behavioral health services. In early March and April, behavioral health and primary care providers scrambled to redesign their care models to include exponential expansions of telehealth in order to ensure ongoing access to care among their patients.

The transition to remote care has been welcomed by patients and providers alike, with several early studies demonstrating that patients express an over 90% satisfaction rate with telehealth availability.[3] Providers, too, report high satisfaction with telehealth services.[4,5] There is good evidence to suggest that appropriate telehealth services can achieve better care[6] for less cost[7] and greater patient and provider satisfaction. Early evidence suggests higher patient compliance[8] with scheduled telehealth visits and greater willingness to comply with a care plan.[9]

Telehealth offers the opportunity to address long-standing State healthcare policy priorities, such as advancing integrated care and curbing Medicaid spending over the long term. The State's Medicaid program is under pressure; estimates for new Medicaid enrollees in New York as a result of COVID-related job losses range from 719,000 to 1.44 million,[10] while the State is currently experiencing a $13.3 billion budget shortfall.[11] Telehealth expands access to health care in underserved areas of the State. Increased access to primary and behavioral health care will reduce costly emergency room care and hospitalizations.

Given its rapid integration into primary and behavioral health care, telehealth is now an essential component of the service delivery continuum and a vital lifeline for many consumers. The New York State Council for Community Behavioral Healthcare (NYSCCBH) and the Community Health Care Association of New York State (CHCANYS) have come together to develop State policy recommendations for sustaining access to remote care in the post pandemic period. Remote care can improve access to the critical whole person healthcare services provided to the communities hardest hit by COVID-19.

EVIDENCE SHOWS TELEHEALTH IS A PROMISING METHOD OF DELIVERING CARE

Numerous peer-reviewed research studies report high patient satisfaction,[12] better patient outcomes[13] and higher provider satisfaction[14] with telehealth services in both primary care[15] and behavioral health settings.[16] The ability to increase provider satisfaction is critical given the workforce challenges plaguing New York State's safety net service delivery system. According to the Health Resources and Services Administration, New York State currently has 170 Primary Care Health Professional Shortage Areas (HPSA), 174 Mental Health HPSAs, 131 Dental HPSAs, and 108 Medically Underserved Areas.[17]

In a study reviewing outcomes associated with telehealth from 2012 – 2015, 98% of individuals who received services via telehealth were satisfied with video and sound quality. Additionally, those participating in telehealth visits experienced shorter wait times, shorter visit times and lower travel-related costs.[18] As seen in Figure 1, the findings from these peer reviewed papers are echoed in the satisfaction surveys of New York state patients conducted throughout the pandemic.

Other studies have attempted to evaluate access to and quality of care provided through telehealth. In

one study of 1,734 individuals without a regular care provider, 94% of women and 99% of people reported being "very satisfied" after receiving a telehealth visit. An additional third preferred a telehealth visit to in-person care.[19] A 2017-2018 study involving 102 individuals evaluated transitions of care and compliance for patients leaving the hospital. Patients receiving telehealth were more likely to have had a medication reconciliation than those receiving in-person care. Individuals seen via telehealth were seven times more likely to adhere to medication requirements. The study found that over 99% of users reported that they were confident in the telehealth care they received.[20]

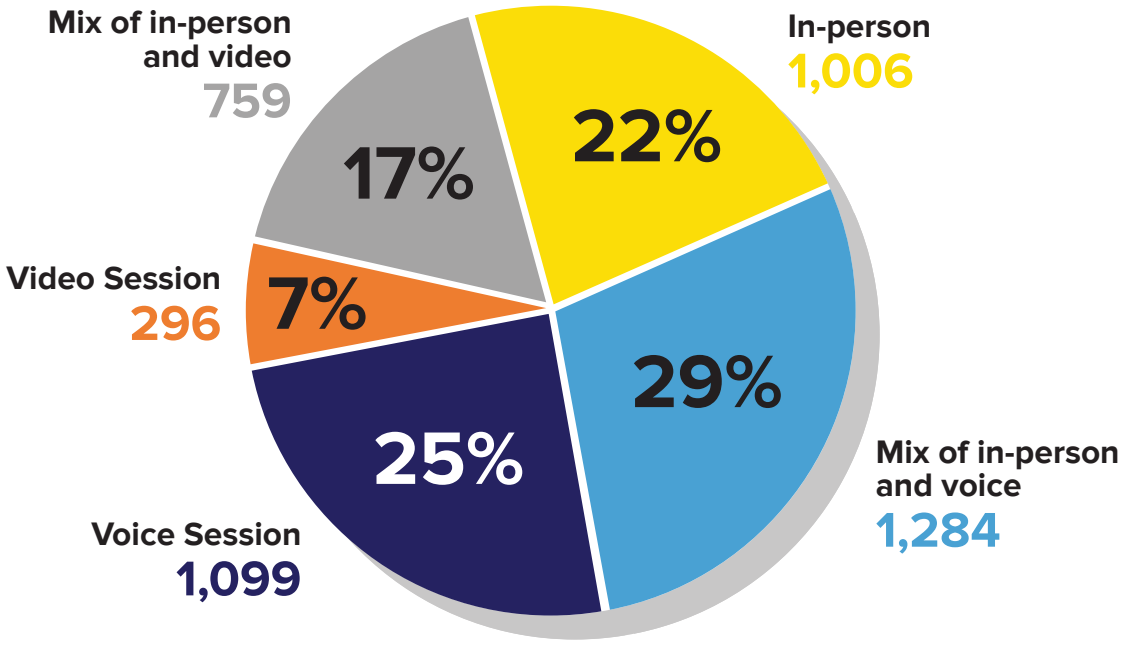


Figure 1. Preferred method of service delivery among Horizon Health clients, 5/19/2-6/8/20

TELEHEALTH IN NYS BEFORE COVID-19

State regulations prior to COVID-19 hindered widespread adoption of telehealth amongst safety net providers. Some regulations restricted the types of technology permitted and others limited the definition of originating and distant sites. Many placed restrictive requirements on what type of provider could use telehealth and which types of services they could provide. These restrictions coupled with low reimbursement rates and impermissibility of audio-only telehealth resulted in very few safety net providers meaningfully utilizing telehealth to deliver services. Results from a recent NYSCCBH member survey (n=36) found that prior to the pandemic, telehealth represented 2% of visits and 2% of revenue across behavioral health sites. Per 2018 Health Resources and Services Administration (HRSA) Uniform Data System reporting, prior to COVID-19, 35% of New York health centers (n=67) utilized telehealth to deliver services.

Restrictive regulations put forth by the Office of Mental Health (OMH) limited widespread adoption of telehealth amongst behavioral health providers. Prohibitive regulations include:

- the requirement that behavioral health practitioners have control over the client's camera,
- restrictions for qualifying originating and distant sites,
- few permissible provider types,
- time limits on patient utilization and
- requirements that a patient receive an in-person visit prior to receiving services via telehealth.

Guidance for both FQHCs and behavioral health organizations required that telehealth be provided using synchronous audio and video systems which limits use among individuals who may not have access to the appropriate technology or who face technical literacy challenges. This is especially true for individuals with intellectual or developmental disabilities, individuals with limited English proficiency, rural residents and older populations. Lack of reimbursement for telephonic visits exacerbates health disparities for individuals that do not have access to the technology, infrastructure, and technical literacy needed for audio-visual telehealth.[21]

Additionally, low levels of reimbursement hindered audio-visual telehealth adoption among safety net providers, many of which already operate on thin margins. FQHCs were not able to receive supplemental wraparound payments for telehealth delivered to patients at home. Medicaid Managed Care reimbursement rates were often much lower than fee for service Medicaid. Across the board, most visits provided via telehealth were reimbursed at much lower rates than services delivered in-person.

A common misconception is that services provided remotely are cheaper to provide than in-person services. However, there is no evidence to support this assumption. In general, 75% of a safety net provider's overhead costs are related to salary and fringe benefits. Additionally, other costs related to physical plant footprint are hard costs, either because organizations have mortgages or long-term leases. Overall, costs are not necessarily reduced in the short-term through telehealth expansion. Further, expanding telehealth requires both upfront and ongoing investments in information technology, operational systems, human resources, call centers and development of new care teams and workflows.

CHCANYS and the NYSCCBH fear that without action from the State, innovation will be stifled and providers will roll back their newly established models of care, which in turn will limit access to remote care among safety net provider patients.

TELEHEALTH IN NYS DURING COVID-19 RESPONSE

New York State responded quickly to the COVID-19 pandemic and provided reimbursement and regulatory relief to assist health care providers in expanding telehealth. However, this regulatory relief is time limited; it is only approved through the duration of the COVID-19 public health emergency. In Table 1, we have summarized a sampling of State emergency flexibilities that have been critical to expanding the adoption and use of telehealth at FQHCs and behavioral health organizations.

State Regulator	Pre-COVID Restrictions	Emergency Flexibility
Office of Addiction Services and Supports (OASAS)	• Required written authorization from OASAS to begin telehealth services • Required client to have on face-to-face encounter prior to telehealth • Limited practitioners eligible to provide telehealth • Had strict requirements on space occupied by both practitioner and client • Required practitioner to maintain control of client's camera • Required services be at an OASAS certified location • Telephonic services not allowed	• Providers are eligible to self-certify to begin telehealth • Clients can begin care in telehealth • Scope of practice expanded to other care providers • Restrictions on space occupied are waived, but HIPAA provisions intact • Practitioner is not required to control client's camera • Waived; services can be provided remotely • Telephonic services allowed
Department of Health, Office of Health Insurance Programs (OHIP)	• Originating site must be at a licensed facility • To receive full PPS equivalent, distant site must be at a licensed facility • Reduced payment rate for patients located at home • Providers unable to deliver care from home • Telehealth services delivered to MMC patients are ineligible for supplemental wraparound payment • Telephonic and asynchronous visits are not billable	• Definition of originating site expanded to include patient's home • Distant site definition modified to be anywhere in US, including a provider's home • Reimbursement rate was modified to ensure FQHCs receive full wraparound rate for some telehealth visits • Payment parity regardless of patient location • Telephonic and asynchronous visits are reimbursable (guidance still pending) • Any FQHC provider that is eligible to bill for an in-person threshold visit is eligible to bill for remote visits
Office of Mental Health (OMH)	• Provision of tele-mental health required prior approval • Limited by location of practitioner • Residential services required face-to-face encounter • Most programs required face-to-face encounters with limited tele-service • Involuntary committal required face-to-face encounter • Controlled substances cannot be provided without an in-person visit • Consent for services was required to be in-person and in writing	• Prior approval requirements waived • Location limitations waived • Requirements waived and telemental health allowed • Requirements for in-person encounters waived • Telemental health services are acceptable for involuntary removal • Controlled substances can be prescribed using telehealth • Consent for services can be done via telehealth and verbally

Table 1. State restrictions to telehealth pre COVID-19 and newly issued flexibilities

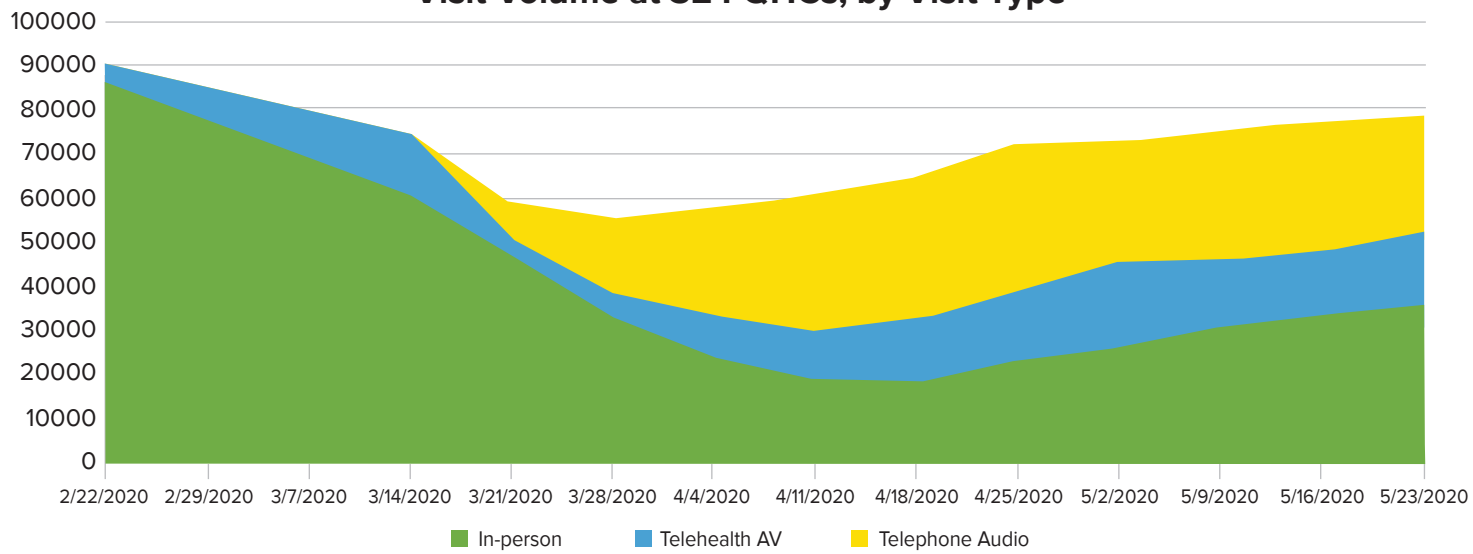
TELEHEALTH IN NYS DURING COVID-19 RESPONSE

Expanded regulatory relief related to telehealth resulted in immediate improvements in access and use of telehealth to deliver care. CHCANYS reports that since March, health centers have had more than 115,800 telehealth visits, including 69,000 audio-only visits. Whereas only 35% of NY FQHCs utilized telehealth in 2018, recent CHCANYS surveys indicate that at least 88% of them now deliver care remotely. The Mental Health Association of Westchester reports that prior to COVID-19, 4.5% of their visits were conducted via telehealth, while during the pandemic that percentage increased to 92% within a span of only four days. This is consistent with other behavioral health providers in New York, who reported through a NYSCCBH survey that, as of mid-June, telehealth comprised 90% of visits and 86% of revenue. NYSCCBH reports that consumers are expressing satisfaction with their telehealth visits. Family Counseling Services of Cortland County reported that 95% of their consumers expressed satisfaction with telehealth as a service modality. BestSelf Behavioral Health in Buffalo reported that their engagement rate (as indicated by attending their first three visits) increased by 15% as a result of telehealth.

Remote access to care by telephone is a matter of health equity for disadvantaged populations, especially those located in areas that have been most adversely impacted by the COVID-19 public health emergency. Many patients face barriers to accessing audio-visual care, including lack of sufficient data plans on mobile phones, lack of computers, and lack of internet access. According to a recent CHCANYS survey, 68% of community health center (CHC) visits are happening remotely with 33% occurring via the telephone. Providers surveyed by NYSCCBH report that 63% of their telehealth visits are being provided with audio only. Early data indicate that consumers prefer an audio-only option. Family Services, in Poughkeepsie, surveyed their clients (n=887) and found that 83% enjoy having an audio-only option, 89% say they feel connected with their provider over the phone, and 77% feel they are able to make progress on their treatment goals by having sessions over the phone.

The impact of this rapid deployment of telehealth was significant. Many NYSCCBH members who had seen rapidly declining visit rates were stabilized. Surveyed providers reported that their in-person visit volume dropped by an average of 23% at its worst point, but that with telehealth, the current volume is only 14% lower than usual. CHCANYS members experienced a similar pattern. An early CHCANYS financial analysis found that collectively, health centers were experiencing losses of $30 million per week at the beginning of the pandemic. After the rapid adoption of telehealth, those l osses have been trimmed significantly and many FQHCs are increasing visit volume, nearing pre-COVID-19 levels.

Visit Volume at 32 FQHCs, by Visit Type



TELEHEALTH IN NYS DURING COVID-19 RESPONSE

Among behavioral health and FQHC providers, client no-show rates have dropped substantially. Barriers such as lack of transportation or childcare have been minimized thanks to telehealth, resulting in the potential for more consumers to become engaged in care. Telehealth has been essential in helping patients avoid COVID-19 exposure both on public transportation and in the clinical setting. Finally, the ability to provide services via the telephone has been critical for establishing remote connection with patients who have historically been unable to take advantage of audiovisual telehealth.

ENVISIONING REMOTE CARE POST-PANDEMIC

Sustaining regulatory flexibilities that have led to increased access will ensure that safety net patients continue to receive care via the modality that best suits their needs. Future models of health care delivery must include a full range of care modalities, including in-person, audiovisual and audio-only telehealth. Providers must be afforded the flexibility to develop care teams and workflows that maximize efficiency and quality of care as well as provider and patient satisfaction. However, this will not be accomplished without the continued flexible regulatory and reimbursement models that allow for a full range of telehealth modalities.

Many individuals served by safety net providers lack access to the technology or resources needed to engage in audio-visual telehealth. Costs of hardware with videoconferencing capability and lack of broadband access can prevent clients from accessing telehealth.[22] Removing the ability to receive reimbursement for audio-only services in a post pandemic period will likely exacerbate exisiting health inequities.

Even before the COVID-19 pandemic, safety net providers struggled to recruit and retain qualified practitioners, adding to existing access to care challenges. Almost 80% of New York's behavioral health workforce needs are unmet,[23] and turnover rates of 35-40% are not uncommon. Practitioners demand a healthy work/life balance, seeking flexibility in work hours and location. Pivoting to remote care could result in higher employee job satisfaction over the long term and may help ameliorate some of the recruitment and retention issues suffered by FQHCs and behavioral health organizations. Moreover, it will provide practitioners the opportunity to reach more patients across a larger geography, improving access for hard to reach areas.

> “
>
> The insights telehealth has given into the daily lives of our patients have been incredible. We have been taken on virtual walking tours of dairy farms, shared work breaks with essential workers, ridden empty buses through distant Upstate towns, been shown awful tent living conditions and provided sleeping bags in response.
>
> We've realized how much we'd been missing from the stories we thought we knew, and this has enabled us to provide more informed care.
>
> ***—Elizabeth Ryan***
> ***Telehealth Must Stay After COVID-19 to Save Our Patients From Overdose, Filter Magazine***

JOINT POLICY RECOMMENDATIONS FOR A POST PANDEMIC PERIOD

To ensure that telehealth becomes a valuable resource for people served by the safety net, we recommend that the State adheres to a set of core principles for determining telehealth regulatory and reimbursement structures:

1. **Utilize telehealth to increase access and promote health equity through support for the full range of telehealth modalities.**
2. **Maximize regulatory flexibilities to sustain telehealth adoption.**
3. **Clinicians, in collaboration with clients, determine when a telehealth visit is appropriate.**
4. **Reimburse telehealth visits on par with in-person visits to ensure a comprehensive, coordinated and integrated continuum of care.**

The following policy changes are recommended to enact these principles:

1. Utilize telehealth to increase access and promote health equity through support for the full range of telehealth modalities.

- **Reimburse telephonic visits post pandemic.** Lack of access to technology is an equity issue that disparately impacts poor communities, which are disproportionately people of color. Many individuals face technical barriers to care in accessing telehealth. This is true in poor communities and neighborhoods where internet access or cell service may not be a given, in rural communities where broadband coverage remains sparse, and with individuals who have developmental disabilities, don't routinely use technology or lack English proficiency. As telehealth becomes more widely available, failure to reimburse telephonic visits on par with in-person visits will reduce usage for some populations, potentially exacerbating existing health inequities.
- **Invest in strategies to address the technology divide.** Improve broadband access and cellular service in rural areas and expand free wi-fi and cellular service in urban areas. Continue New York's plan to expand broadband access to all remote and rural communities in New York State. Continue to ensure wi-fi access in public housing and low-income neighborhoods. Ensure individuals across the State are able to utilize telephonic services regardless of location by expanding the number of cellular towers in rural and urban communities.

2. Maximize regulatory flexibilities to sustain telehealth adoption.

- **Continue the emergency expansion of allowable licensed practitioners to provide telehealth care.** Telehealth is a modality, not a service, and licensed practitioners that can deliver care in-person can also deliver excellent care remotely for those services that are appropriate. In addition, the State should immediately make reimbursement for peer services provided through telephonic only and other modalities reimbursable.
- **Do not require in-person visits prior to telehealth visits.** Telehealth visits can be appropriate whether the clinician and client have met face-to-face or not. For example, across the State, lengthy travel times and childcare challenges can impede in-person visits. In such instances, telehealth serves as an appropriate first access point.
- **Support remote group and family therapy visits.** Permit telehealth visits for group therapy sessions and family therapy visits. Tele-group therapy will enhance individuals' ability to access group therapy (an effective and efficient treatment modality) in ways that enable practitioners to establish harmonious and well-balanced groups. Patients beginning outpatient group services for substance use disorder often find group sessions via telehealth to be less intimidating. Similarly, tele-family therapy can prove essential if families are spread across wide geographic areas.

JOINT POLICY RECOMMENDATIONS FOR A POST PANDEMIC PERIOD

- **Invest in workforce training and research to establish an evidence base.** Clinicians across the state have done heroic work during the pandemic making the shift to telehealth. They, and their supervisors, will need training in telehealth clinical methodologies in order to maximize telehealth's benefit for their clients. To develop effective protocols, research is needed to truly understand where and when telehealth is most impactful (and when it is not). Research of the scope and scale necessary will not be possible for any individual provider to conduct.
- **Permit electronic signatures.** Enabling the electronic and verbal signing of consents and other necessary client approvals will facilitate the efficient and rapid access that should be a hallmark of the hybrid service delivery model.
- **Allow for case conferencing and collateral visits to be done remotely.** Case conferences and collateral visits should be consistently reimbursed and permitted via videoconference.
- **Do not limit the number or percentage of visits that can be administered using telehealth.**
- **Reform CON/PAR**. As possible, consider whether safety net providers with a full operating certificate and extension clinics continue to need separate applications for extension sites when telehealth is a significant component of the service delivery model. The historically site-based licensing model needs to be reconsidered in response to this new service delivery model.

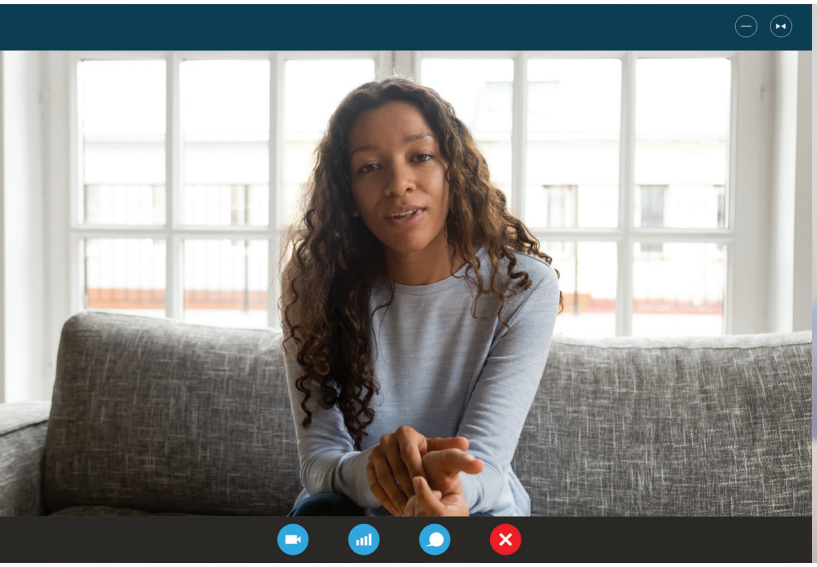
3. Clinicians, in collaboration with clients, determine when a telehealth visit is appropriate.

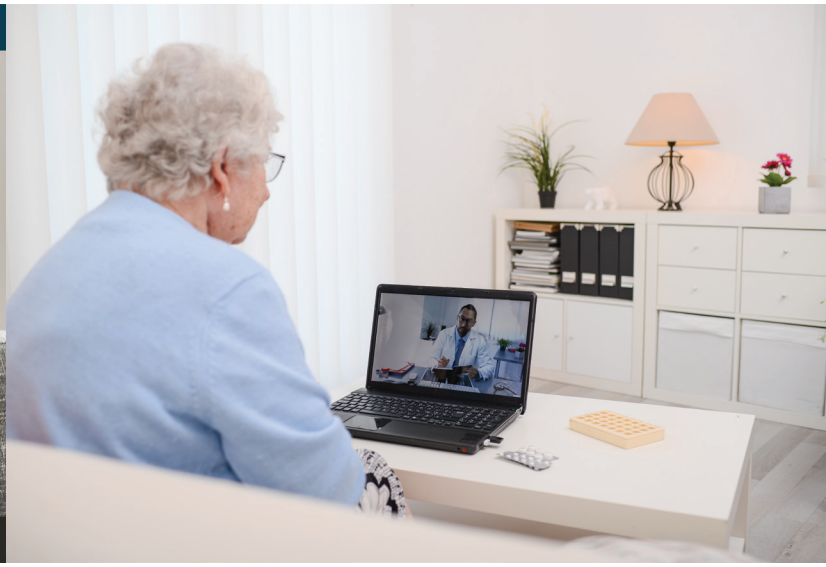
- **Treat telehealth as a "tool" in the health care toolbox and leave discretion for its use with the clinician in collaboration with the client, based on patient needs and capacity.** Industry-accepted best practices are needed to guide clinicians' decisions about treatment modalities. At the same time, practitioners will need to tailor care to promote the best outcome possible based on each consumer's need and preferences. Clinical decision-making and consumer choice must drive care delivery. Regulations should permit the least intensive viable technology based on clinical considerations and consumer preference.

4. Reimburse telehealth visits on par with in-person visits to ensure a comprehensive, coordinated and integrated continuum of care.

- **Provide reimbursement parity for all telehealth visits.** Maintain supplemental wraparound payments for telehealth visits at FQHCs. Reimburse all Article 28, 31, and 32 visits on par with face-to-face services regardless of whether the telehealth is audio-visual or audio only.
- **Consider an Alternative Payment Methodology (APM) for primary care and behavioral health providers.** A capitated APM model would alleviate altogether the need for the state to count and pay for each different visit type and care delivery modality. If providers can be paid a lump sum amount for care of a patient, innovation can allow for more efficient models of care. Without meeting a "threshold" for billing, nurses can provide screening and education via tele phone to patients at times that are convenient to both, while only having to come to a provider site for a physical exam. The pandemic highlighted the need for a payment methodology that incentivizes providers to focus on population health rather than visit volume. An APM provides flexibility to allow practitioners to innovate with care teams and workflows, allowing all provider types to operate at the top of their profession. Additionally, a capitated APM would enhance care integration among FQHCs and behavioral health organizations. APMs allow safety net providers and the State to budget more effectively. Ultimately, an APM would safeguard the safety net against system disruptions such as the COVID-19 outbreak.

CONCLUSION





In order to sustain expanded access to care that has resulted from increased remote care delivery, the State must consider making permanent many of the flexibilities telehealth afforded during the COVID-19 pandemic. Audio-only services have reduced no-show rates, improved compliance with behavioral health treatment models and expanded access to services for patients that have historically been unable to take advantage of audio-visual telehealth due to technical and financial limitations. Safety net providers have also expanded audio-visual telehealth, ensuring that patients are able to take advantage of a full range of care delivery options. Patients and providers cannot be expected to revert back to old care models in the face of the innovation started during the COVID-19 response. CHCANYS and the NYSCCBH look forward to collaborating with the State to ensure that all New Yorkers continue to have access to comprehensive whole person primary and behavioral health care both remotely and in person.

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Journal of Health Care for the Poor and Underserved

2009 Feb;20(1):165-76

Racial/ethnic disparities in mental health treatment in six Medicaid programs

Mihail Samnaliev[1], Mark P McGovern, Robin E Clark
Affiliations expand

PMID: 19202255

Abstract

Little is known about ethnic and racial disparities in mental health care among Medicaid beneficiaries. The association between ethnicity and race and the utilization of mental health care was explored in six Medicaid programs. The analysis distinguished between different settings of care, including community-based, outpatient hospital, inpatient, and emergency departments (EDs). Racial and ethnic disparities in mental health care were observed across state Medicaid programs. Hispanic and African American beneficiaries with mental illness were much less likely than Whites to be treated in community-based settings. African Americans were more likely to receive mental health treatment in inpatient, ED, and outpatient hospital settings in some states. The implications of these findings and possible initiatives to enhance community-based mental health care among African American and Hispanic Medicaid beneficiaries are discussed.

Administration and Policy in Mental Health and Mental Health Services

2009 Nov;36(6):424-31.

Distance matters in choice of mental health program: policy implications for reducing racial disparities in public mental health care

Naoru Koizumi [1], Aileen B Rothbard, Eri Kuno
Affiliations expand

PMID: 19653093

Abstract

The purpose of this study is to examine the influence of race, geographic distance and quality on the choice of community mental health programs. The study population was comprised of adult Medicaid recipients who received outpatient treatment for serious mental illness in FY 2001. A discrete choice model was employed to examine the likelihood of choosing one program over another. Quality was measured based on follow-up after hospital discharge and continuity of care in outpatient services. Maps showing the relationship between race and the quality of care were prepared to visually confirm the results of the statistical analysis. African American and Hispanic clients were less likely to travel further for treatment, while no significant difference was found between the Caucasian and other race groups. Caucasian subjects were more likely to choose programs with a higher quality of care compared to Hispanic or African American clients. Higher income clients were, on average, traveling longer and receiving better quality of care after controlling for race. The results suggested that clients living in higher income White neighborhoods are more likely to travel longer distances for mental health treatment. Special attention must be paid to improve the quality of care in lower income minority neighborhoods to insure equity of treatment in publicly funded programs.

ROCHESTER REGIONAL HEALTH

BEHAVIORAL HEALTH AMBULATORY TELEHEALTH COMPLETION RATE ANALYSIS

COVID IMPACT
TELEHEALTH CONSIDERATIONS

Regulatory Compliance

Interface & Equipment Selection

Define Clinical Best Practice

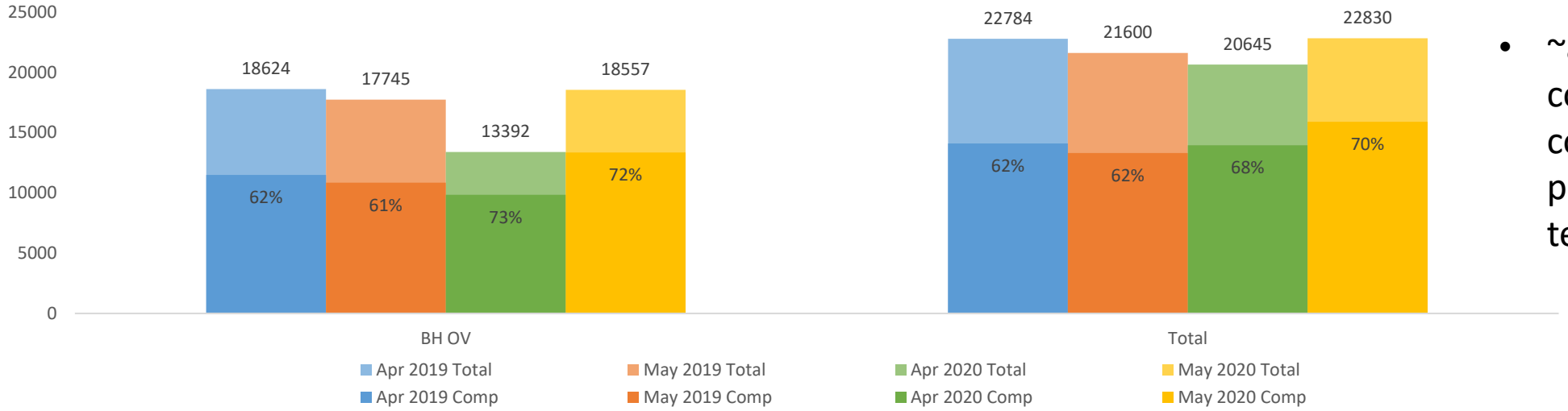
Training

Revenue Cycle Planning

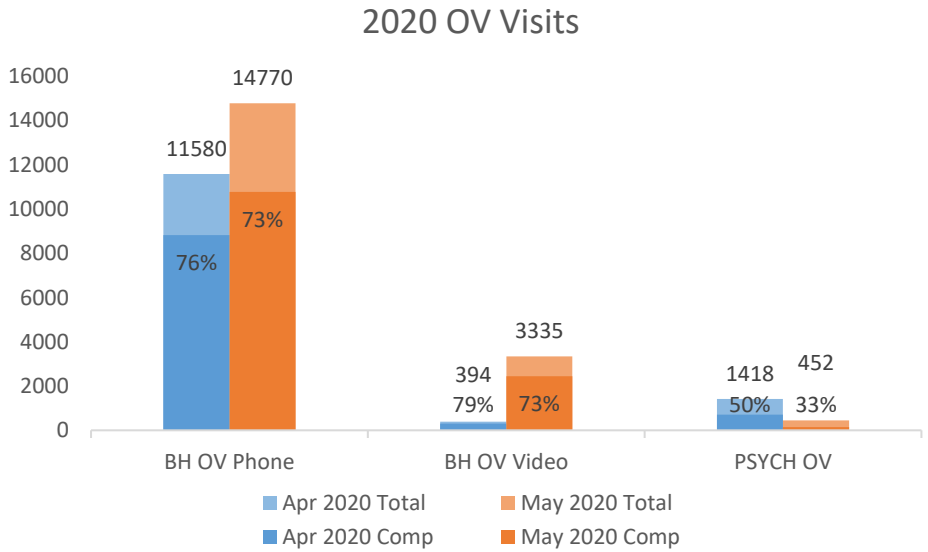
Continuous Improvement

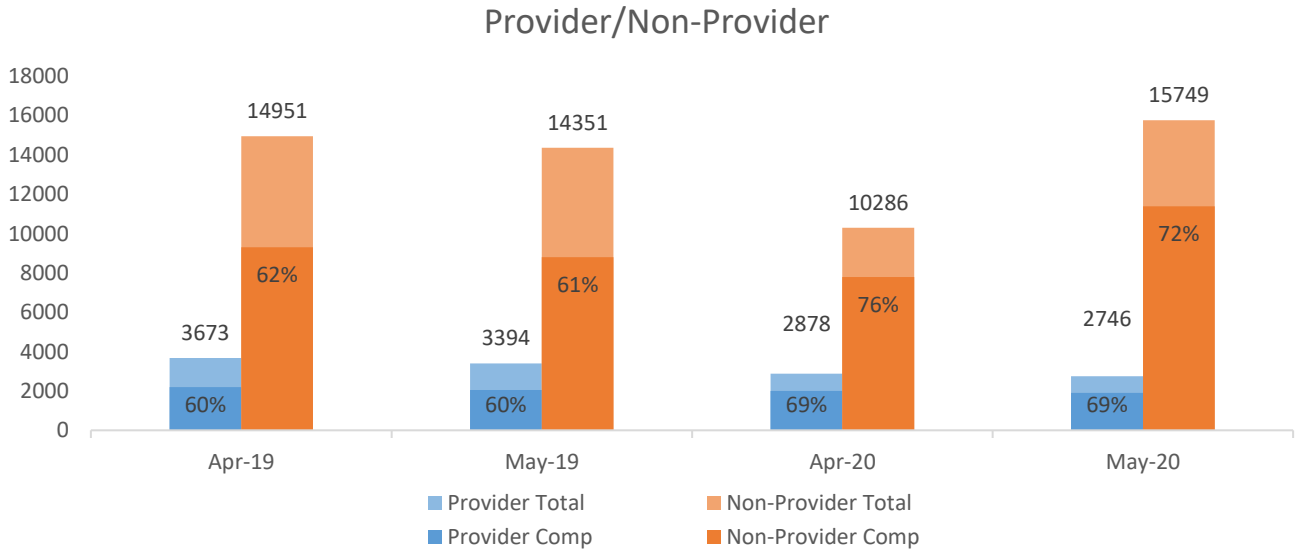
AMBULATORY MENTAL HEALTH

IN-PERSON VS TELEHEALTH COMPLETION RATE COMPARISON



- ~8-10% Increase in completion rate comparing in-person visits to telehealth

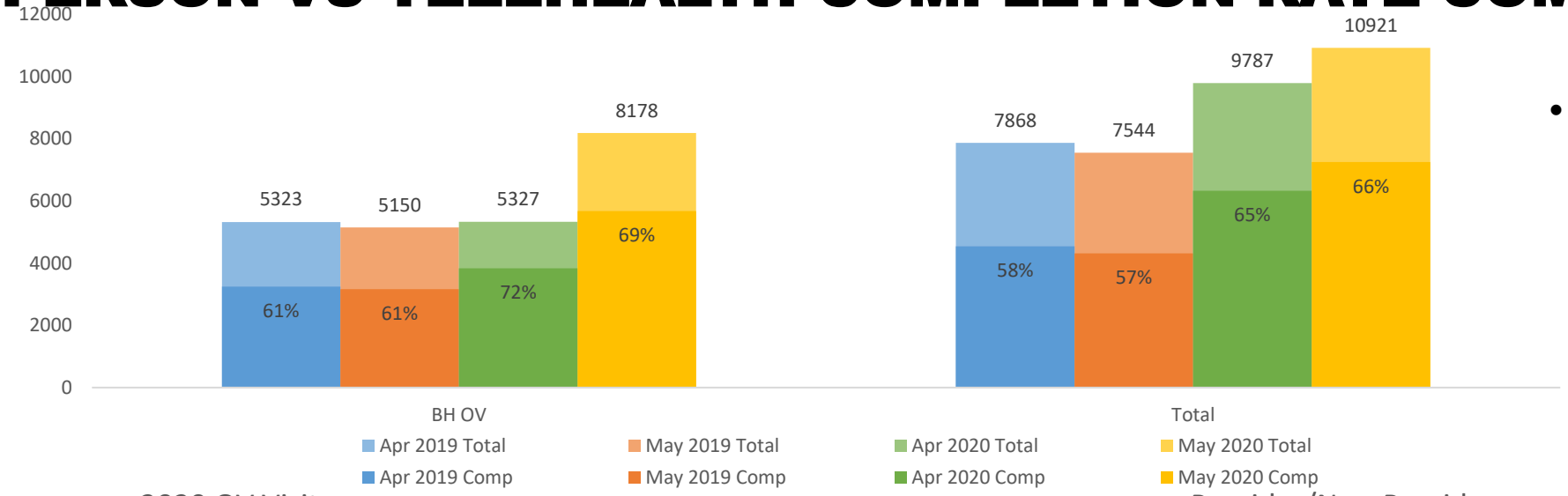




ROCHESTER REGIONAL HEALTH

AMBULATORY CHEMICAL DEPENDENCY

IN-PERSON VS TELEHEALTH COMPLETION RATE COMPARISON



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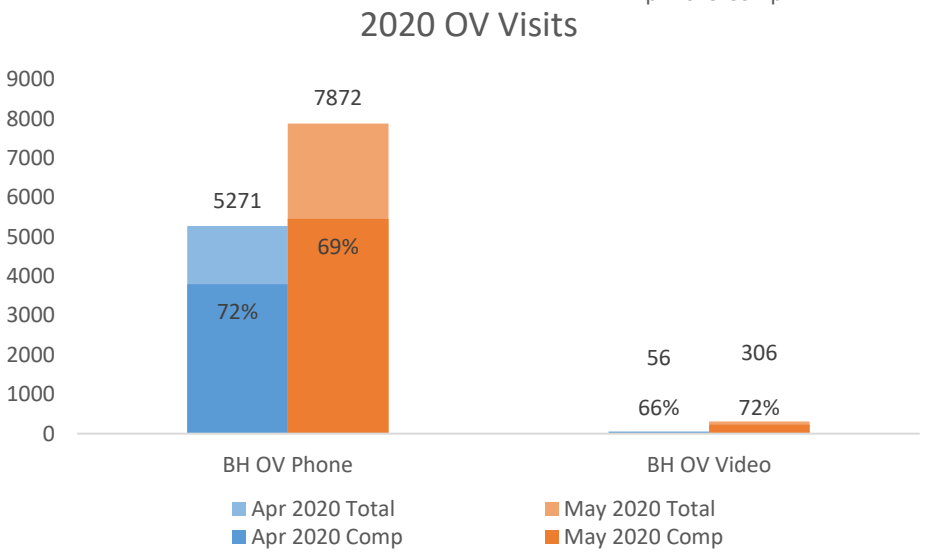

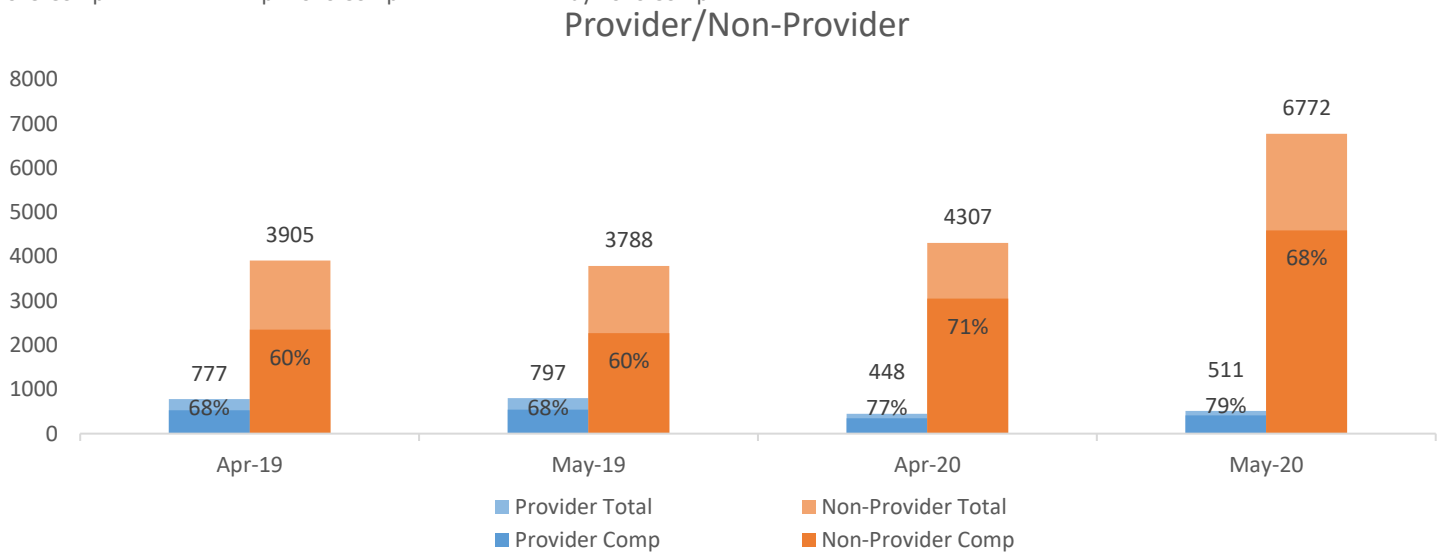

ROCHESTER REGIONAL HEALTH

COVID IMPACT
TELEHEALTH FACTORS DRIVING SUCCESS

Regulatory Compliance

- Coordinated application submission
- Continuously monitor changes
- Plan for the future state
- Define best practice when it doesn't exist

Interface Selection

- Flexibility in modalities
- MyCare not widely adopted by BH patients
- Interface for groups a requirement (Zoom)

Revenue Cycle Planning

- Partnership with Revenue Team
- BH = no rate degradation
- Nimble modifications to CC for charge capture
- Track impact

Continuous Improvement

- Weekly Tracking of Data
- Budgeted/Actual Visits
- Tele Offerings
- Tele Completion Rate
- New Patient Volume

- Data discussed weekly with all BH leaders

Regional Planning Consortium

QUARTER TWO UPDATE

APRIL 1 – JUNE 30, 2020

NYS Conference of Local Mental Hygiene Directors, Inc.

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CLMHD Regional Planning Consortium

RPC CENTRAL OFFICE - ALBANY
Lori Kicinski, RPC Project Director
Katerina Gaylord, Assistant RPC Project Director

TUG HILL/SEAWAY REGION
Tim Ruetten, DCS, Jefferson County
Jennifer Earl, Government Liaison, United Health Care/Optum
Beth Solar, RPC Coordinator

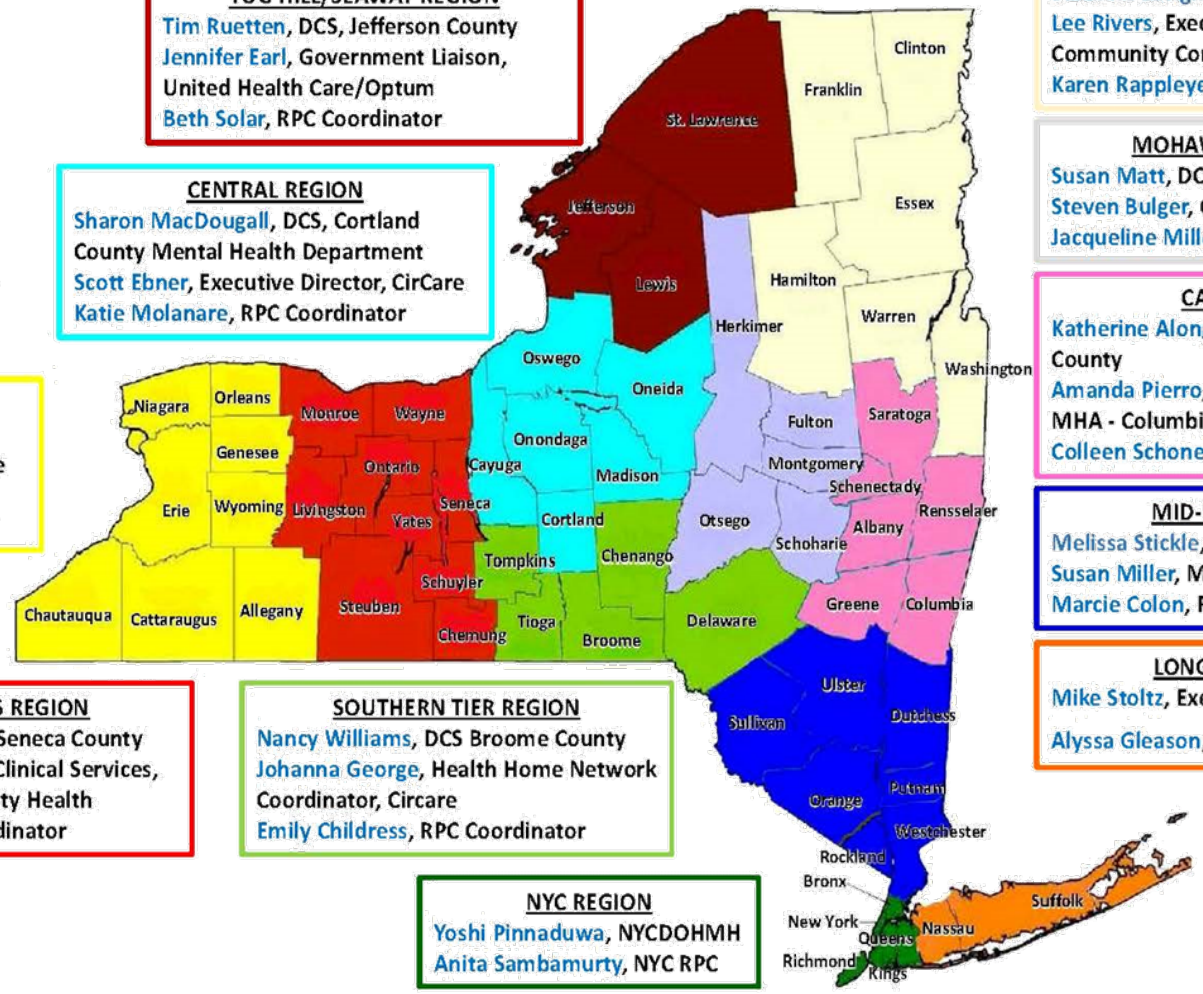
CENTRAL REGION
Sharon MacDougall, DCS, Cortland County Mental Health Department
Scott Ebner, Executive Director, CirCare
Katie Molanare, RPC Coordinator

WESTERN REGION
Mark O'Brien, DCS, Erie County
Kirsten Vincent, Director Respite Services - Housing Options
Tiffany Moore, RPC Coordinator

FINGER LAKES REGION
Margaret Morse, DCS Seneca County
Ellen Hey, Director of Clinical Services, Finger Lakes Community Health
Beth White, RPC Coordinator

SOUTHERN TIER REGION
Nancy Williams, DCS Broome County
Johanna George, Health Home Network Coordinator, Circare
Emily Childress, RPC Coordinator

NYC REGION
Yoshi Pinnaduwa, NYCDOHMH
Anita Sambamurty, NYC RPC



NORTH COUNTRY REGION
Suzanne Lavigne, DCS Franklin County
Lee Rivers, Executive Director of Community Connections of FC
Karen Rappleyea, RPC Coordinator

MOHAWK VALLEY REGION
Susan Matt, DCS Otsego County
Steven Bulger, CEO, ICAN
Jacqueline Miller, RPC Coordinator

CAPITAL REGION
Katherine Alonge-Coons, DCS Rensselaer County
Amanda Pierro, Director Apogee Center, MHA - Columbia-Greene
Colleen Schoner, RPC Coordinator

MID-HUDSON REGION
Melissa Stickle, DCS Sullivan County
Susan Miller, Managing Director RSS
Marcie Colon, RPC Coordinator

LONG ISLAND REGION
Mike Stoltz, Executive Director, MHWA
Alyssa Gleason, RPC Coordinator

RPC Mission & Purpose

Who We Are:

The Regional Planning Consortium (RPC) is a network of 11 regional boards, community stakeholders, and Managed Care Organizations that work closely with our State partners to guide behavioral health policy in the regions to problem-solve and develop lasting solutions to service delivery challenges.

RPC Mission Statement:

The RPC is where collaboration, problem solving and system improvements for the integration of mental health, addiction treatment services and physical healthcare can occur in a way that is data informed, person and family centered, cost efficient and results in improved overall health for adults and children in our communities.

About this Report:

The content of this Report targets Quarter 2 (Q2) (April 1 – June 30, 2020) activities conducted by the rest-of-state RPC by Region.

RPC Pandemic Response

As COVID-19 began sweeping the globe and the focus of all communities shifted to adjusting to the demands of the pandemic, the RPC team remained dedicated to solving problems regionally to best assist our stakeholders during this unprecedented time. Although many of the issues established in Q1 by region may have "paused" with the rest of NYS, several new projects were completed and initiatives established during Q2:

- **Mental Health Access Survey:** derived from an OMH website listing of provider organizations, 343 programs were identified; 311 were telephonically contacted, providing specific information regarding their ability to provide intra-muscular (IM) injections, and an estimate of the percentage of their services being provided by telemental health.
- **Behavioral Health Crisis Resource Guide**: RPC Regional staff created comprehensive and timely listings of county, regional, state, and national resources for stakeholders into a consolidated directory for ease of access during a challenging time.
- **RPC Service support to OMH for COVID-19 response activities** from April 23, 2020 through June 22, 2020.
    - Personal Protective Equipment (PPE) survey development and data analysis to assist OMH with collecting regionally specific information related to PPE and Office of Emergency Management (OEM).

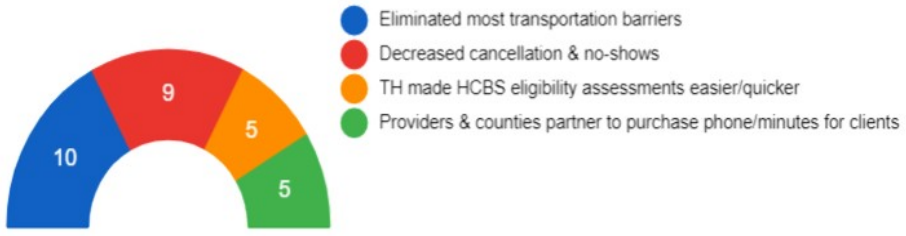
RPC Pandemic Response

COVID-19 Telemental Health Tracker - The RPCs catalogued remarks related to telehealth during the COVID-19 State of Emergency from March 12 through June 5. The information collected during this timeframe will be used to inform dialogue during the October 29, 2020 Virtual State/Co-Chairs Meeting. In addition to access, topics will include service delivery, workforce, telehealth sustainability, revenue cycle management during/post COVID-19, and client experience and feedback.

ACCESS DEFINITION

Ability to access services, including challenges to access, timely ability to schedule and receive services.

TOP ACCESS REMARKS (by Frequency)



Access Remarks by Population (n=18)

TOP ACCESS REMARKS

In 5 Regions (Adult & Child Population): Providers are partnering with their counties and other providers (i.e. Unitedway) to utilize funds and purchase more phones and minutes for clients as many still do not have working phones

In 5 Regions (Adult Population): Telehealth option has increased ability to get needed assessments done for HCBS eligibility quicker and easier as many barriers eliminated.

In 9 Regions (Administrative):Seeing a decrease in cancelled/no-show appointments through telemental health. Clients are more consistently engaging in services with the telehealth option. A hybrid of being able to do in-person, but use telehealth when needed would be beneficial

In 10 Regions (Adult & Child Population): Telehealth has eliminated some transportation issues for clients. Able to engage in more services with this barrier being eliminated. Also decrease appointment cancellations for transportation issues.

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2020 RPC Areas of Focus

Behavioral Health Workforce

- Central New York RPC concluded pilot with Syracuse University on Care Coordination Certificate Program
- Collaboration with Office of Consumer Affairs on how to best engage Peer, Family, Youth Advocates in the RPC with future collaborations planned
- Establishment of Statewide Peer/Family/Youth Stakeholder meetings and appointment of Group Leads
    - Kirsten Vincent, Western Region Co-Chair and Amanda Pierro, Capital Region Co-Chair

Children & Families

- CFTSS and HCBS Capacity Survey gaining traction across regions with Mid-Hudson joining Long Island and Mohawk Valley in data collection
- Collaboration with Interagency Technical Assistance Team (OASAS, OMH, OPWDD, OCFS) on the technical assistance needs of providers related to the children's transition
- Reestablishment of the Statewide Children and Families Co-Lead Meeting to ensure continuity of voice and focused collaborative initiatives across all regions – to be launched in July 2020.

Innovations in Value Based Care

- Planning for Inaugural "RPC Managed Care Roundtable" meeting in July 2020

Social Determinants of Health

- Examining statewide strategies for Co-Occurring Systems of Care, Transitions in Care for homeless adults with recent psychiatric admissions, and housing options for the behavioral health population

2020 RPC Areas of Focus

In Q2, from a statewide perspective, the RPC continued to develop our four Areas of Focus in 2020. In cooperation with the impactful work occurring within our Boards across the state, common statewide drivers continue to evolve and the RPC has established formalized, agile Project Concentration Cohort teams to carry our collective voice. These teams will work to ensure subject matter expertise, communications and issues are consistently shared across settings to include agency partners within our four domains:

VBP/ Managed Care: Primary Care Integration	LORI KICINSKI	BETH SOLAR	BETH WHITE
SDOH/ Care Transitions and Co-Occurring Integration	MARCIE COLON	COLLEEN RUSSO	KAREN RAPPLEYEA
Behavioral Health Workforce	KATIE MOLANARE	EMILY CHILDRESS	TIFFANY MOORE
Children and Families	JACQUELINE MILLER	ALYSSA GLEASON	KATERINA GAYLORD

For further information about the Regional Planning Consortium, please contact:

RPC Project Director: Lori Kicinski, (518) 867-1159

RPC Assistant Project Director: Katerina Gaylord, (518) 396-0788

Capital Region

DCS Co-chair: Katherine G. Alonge-Coons, LCSW-R, Rensselaer County

Community Co-chair: Amanda Pierro, Peer Representative

RPC Coordinator: Colleen Russo

Board Membership: Capital Region RPC Board Members

Click HERE to visit the Capital Region RPC web page

Meetings Held During Quarter 2

- Q2 Board Meeting – 5/18
- C&F Subcommittee Meeting – 6/29
- HHH Workgroup Meeting – 4/16, 4/30, 5/12

Q2 Top 3 Issues: Identification & Issue Development/Due Diligence

- Workforce development, staff recruitment and retention concerns continue as staff turnover remains high in care coordination and HCBS settings.
- There are growing waitlists for CFTSS, children's HCBS and adult HCBS services. It is difficult to find a designated provider accepting referrals at time of referral submission. In addition, waitlists are lengthy and the referral process is often unclear.
- Lack of safe housing discharge resources for homeless adults who are admitted for inpatient psychiatric treatment is resulting in an increased length of stay and an increased probability of re-admittance.

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Capital Region continued

Next Steps

- Pursue Capital Region representation on Statewide RPC workforce workgroup to discuss solutions on recruiting and retaining qualified staff, and to provide input on workforce issues that cannot be addressed regionally.
- C&F and HHH workgroups will develop and pilot surveys in Q3 for children's CFTSS and HCBS and adult HCBS services to determine provider capacity, designation status, services offered, waitlist status and up-to-date information on agency's referral processes to better facilitate the connection of adults, children and families to needed services.
- Transitions in Care Workgroup will reconvene to address the previously identified issue of homelessness and transitioning psychiatric patients from inpatient settings.

Achievements & Upcoming

- Engaged new chairpersons for the Health Home/ HARP/ HCBS Workgroup and Transitions in Care Workgroup. This will bring a new perspective and leadership to further RPC initiatives.
- Transitions in Care Workgroup will be hosting a presentation in August 2020 regarding the Galvan Foundation, which has partnered with Columbia County DSS and the MHA of Columbia-Greene County to address homelessness within their community.

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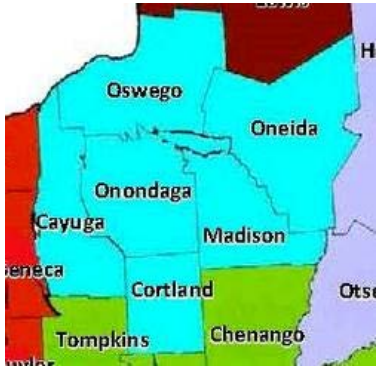
Central NY



DCS Co-chair: Sharon MacDougall, MSW, MBA, MS, LCSW-R, Cortland County Mental Health Department

Community Co-chair: Scott Ebner, Executive Director, Circare

RPC Coordinator: Katie Molanare

Board Membership: Central NY RPC Board Members

Click HERE to visit the Central NY RPC web page

Meetings Held During Quarter 2

- Q2 RPC Board Meeting- 5/4 (Quarterly) – Minutes Pending Approval (Sept 2020)
- HARP/HCBS/Health Home Workgroup – 4/22, 5/20, 6/17 (Monthly)
- Care Manager Roundtable Group – 5/7, 6/11 (Monthly)
- Workforce Development Committee – 5/28 *Switched to Bi-Monthly*
- C&F Subcommittee – 4/10, 5/15, 6/12 *Switched to Monthly*
- State RPC Workforce Committee – Postponed May Meeting (Bi-monthly)
- VBP Newsletter- Sent out Bi-monthly with BHCC updates – No Updates For June

Q2 Top 3 Issues: Identification & Issue Development/Due Diligence

- State educational/experience requirements for Health Home/HCBS Care Management staff have left providers with increased job vacancies leading to increased burnout and turnover from existing care managers due to high caseloads.
- The process of informed consent has brought up much confusion, particularly around the number of forms a client must sign, which forms providers require, and the comprehensive knowledge of each form that must be communicated by staff members.
- Obtaining behavioral health translation services is extremely difficult. There is a disparity between medical and behavioral health translation services. Confusion around the shared responsibility between MCOs, providers, and care management.

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Central NY continued

Next Steps

- Data collection completed for Syracuse University Care Coordination Pilot. Results will be shared with appropriate workgroups and committees. In addition, the Workforce Committee will send out a Recruitment Survey in August 2020 to continue gathering data around best practices to recruit and retain newly hired front line staff.
- Continuing to gather additional information around Informed Consent from Peer Forums/Groups, as well as, from Privacy Officers within HCBS agencies.
- Presenters from OMH's Bureau of Cultural Competence have agreed to present at Q3 BOD Meeting in September 2020 regarding education around Language Assistance/Translation Services. Workgroups continue to discuss this issue regularly.

Achievements & Upcoming

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Finger Lakes

DCS Co-chair: Margaret Morse, LMSW, Seneca County

Community Co-chair: Ellen Hey, MS, FNPC, Chief of Quality, Finger Lakes Community Health

RPC Coordinator: Beth White

Board Membership: Finger Lakes RPC Board Members

Click HERE to visit the Finger Lakes RPC web page

Meetings Held During Quarter 2

- CFTSS/HCBS Sustainability Learning Collaborative – 4/13, 5/4, 5/21, 5/27
- Finger Lakes RPC Board – 5/15
- Overview of "820 Setting – Continuation of Managed Care Coverage" – 6/15
- Future of Telehealth Workgroup – 6/19
- Hospital System Meeting re PA Practice in MH Clinics – 6/25
- Physician Assistant Program at Rochester Institute of Technology (RIT) – 6/25

Q2 Top 3 Issues: Identification & Issue Development/Due Diligence

- Physician Assistant (PA) Scope of Practice in Article 31 Clinics – cannot assess or prescribe without completion of OMH waiver process, resulting in an important workforce resource unable to fully deliver critically needed services to clients
- Children & Families providers report CFTSS/HCBS services not financially sustainable
- Residents of 820 OASAS housing programs are losing Managed Care insurance due to a processing problem at LDSS around the Congregate Care Level 2 application.

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Finger Lakes continued

Next Steps

- Confirm Status of new Physician Assistant Psychiatry Track Curriculum at RIT which may result in PA's being permitted to prescribe in Article 31 Clinic without needing the currently required OMH waiver process
- Convene closing session of CFTSS/HCBS Sustainability Learning Collaborative
- Survey Learning Collaborative participants on the value of the learning tool & the Collaborative experience
- Follow-up with regional 820 OASAS providers to gauge success of the implementation of the formal GIS notice intended to correct the interruption of clients' Managed Care coverage

Achievements & Upcoming

- Finger Lakes Crisis Resource Guide issued – Apr 29
- Convened First Meeting of New Finger Lakes RPC Workgroup – Future of Telehealth
- As a direct result of the work of the WNY RPC, with advisement and support from the Finger Lakes RPC, NYS DOH, OTDA and OASAS jointly issued a formal GIS notice to Local DSS Commissioners correcting the interruption of clients' Managed Care coverage when they are admitted to OASAS 820 settings.

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Long Island

DCS Co-chair: Pending

Community Co-chair: Michael Stoltz, CEO, Association for Mental Health and Wellness

RPC Coordinator: Alyssa Gleason

Board Membership: Long Island RPC Board Members

Click HERE to visit the Long Island RPC web page

Meetings Held During Quarter 2

- Peer Supervision Learning Collaborative – 4/23
- C&F Subcommittee Meeting – 5/7
- Peer Supervision Learning Collaborative – 5/21
- HHH Workgroup Meeting – 6/4

Q2 Top 3 Issues: Identification & Issue Development/Due Diligence

- CFTSS & HCBS Provider Designation & Access- Survey focused on identifying openings and access issues to children's services. Initial results showed many providers designated, but not providing services in both counties.
- Peers in the workforce remains a priority to the LI RPC. We will continue to build the Peer Supervision Learning Collaborative inter-system group to help build skills, knowledge for peer supervisors in all systems, as well as best practices for integrating and maintaining peers in the workplace.
- Proposed changes to adult HCBS services could significantly impact the way the HHH subcommittee was examining the HARP eligible vs. enrolled and HCBS eligible vs. enrolled population.

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Long Island continued

Next Steps

- Continue to send out CFTSS/HCBS Capacity Survey monthly to assess patterns in access to services for children and families. List of providers with openings from most recent survey was sent out to CMA's, CSPOA's, MCO's and OMH Long Island Field Office (LIFO) to assist with linkages.
- The Children & Family subcommittee will convene for an ad hoc meeting on 7/14 to review data and begin discussion on next steps with the committee after May 2020 survey results were analyzed.
- Continue Peer Supervision Learning Collaborative meetings focusing on understanding each unique peer service, building career ladders, and plan for an event/training.
- The HHH subcommittee will regularly discuss the nuances of the proposed BH ARS (Behavioral Health Adult Rehabilitation Services) transition and how they may impact the services provided to adults in this region.

Achievements & Upcoming

- HCBS/CFTSS Capacity survey had an 80% response rate.
- LI Crisis Resource List & LI Peer Support Resource List
- Quarter 3 Children & Family Subcommittee meeting on 8/13. Focus will be to continue to review data from two surveys (May 2020 and July 2020) and plan next steps.

Mid-Hudson

DCS Co-chair: Melissa Stickle, LCSW, CASAC, Sullivan County

Community Co-chair: Susan Miller, Managing Director, Rehabilitation Support Services

RPC Coordinator: Marcie Colon

Board Membership: Mid-Hudson RPC Board Members

Click HERE to visit the Mid-Hudson RPC web page

Meetings Held During Quarter 2

- Q2 Board Meeting – 6/10
- C&F Meeting – 5/26
- Article 31 & 32 Clinic Taskforce – 5/29

Q2 Top 3 Issues: Identification & Issue Development/Due Diligence

- Sustainability of Article 31 & 32 clinics – Clinic taskforce reviewed proposed OMH & OASAS regulatory changes in order to identify how it affects services.
- Integration of services for individuals with mental health and substance use disorders – The Mid-Hudson RPC developed a Co- Occurring System of Care (COSOC) initiative to improve outcomes for individuals with co-occurring diagnoses by engaging providers on how to establish a co-occurring system of care in their communities.
- Underutilization of Adult HCBS – Developed a new Sub-committee to review HCBS data which showed limited utilization of the program. The focus has been on the anticipated regulatory changes to BH ARS and the potential impact on services.

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Mid-Hudson continued

Next Steps

- With support from the WMCHealth (Westchester Medical Center Health) PPS and the Harris Project, the Mid-Hudson RPC will host a Fall COSOC conference to identify best practices when working with co-occurring populations, including individuals with developmental disabilities, mental health and substance use disorders.
- After review of proposed Article 31 & 32 clinic changes, the taskforce will continue to focus on increased flexibility with telehealth, as well as offsite and peer services, to determine how service delivery may be impacted in this region.
- The Mid-Hudson RPC, Health Home/HARP/HCBS subcommittee will review public notice related to HCBS transition to BH Adult Rehabilitation Services (ARS) focusing on the advancement of the Psych. Rehab. Model which is believed to be budget neutral. The taskforce goal is to share state directives and guidance related to the changes with all providers and assist in developing appropriate steps to ensure new regulations are understood and put into place.
- Mid-Hudson RPC Children's HCBS & CFTSS Provider Capacity Survey will continue to be sent to providers in the Mid-Hudson region to better understand capacity and needs for these programs within our region. This will allow agencies easier access for referrals.

Achievements & Upcoming

- Tracked Mid-Hudson specific COVID-19 issues to identify and share providers' concerns and practices related to telehealth and other issues arising during the COVID-19 pandemic.
- COSOC – 3 Part Fall Conference - providing learning opportunities for regional providers. The conference will focus on processes to ensure co-occurring capacity for individual agencies, a best practice entitled "Encompass", as well as specific details and best practices when working with individuals with development delays as well as mental health and substance use disorders.
- The Mid Hudson RPC applied to NY System of Care Conference to present Mid-Hudson COSOC Initiative to assist attendees in better understanding the concept and best practices for developing a coordinated co-occurring system of care.

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Mohawk Valley

DCS Co-chair: Susan Matt, LCSW, CASAC, Otsego County

Community Co-chair: Steven Bulger, CEO/Executive Director, ICAN

RPC Coordinator: Jacqueline Miller

Board Membership: Mohawk Valley RPC Board Members

Click HERE to visit the Mohawk Valley RPC web page

Meetings Held During Quarter 2

- C&F Committee – OPEN to all stakeholders COVID-19 Discussion – 4/24
- Quarter 2 BOD Meeting – 6/5

Q2 Top 3 Issues: Identification & Issue Development/Due Diligence

- Sustainability of telehealth post COVID-19 specifically with Peer Services & Consumer Engagement- There has been a noted increase in engagement and participation in Peer Services with telehealth. The Mohawk Valley will be looking at the sustainability of telehealth post COVID-19 within Peer Service to ensure continued engagement.
- Children's Provider Designation Lists for CFTSS and HCBS are often difficult to navigate and have conflicting information between the various sites that house this information.
- Timely access to behavioral health care has been a challenge in rural regions. As a result, the feasibility around advocacy for sustainable telehealth has been identified as an important topic of discussion at the Q3 HHH subcommittee and Q3 Board of Directors meetings.

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Mohawk Valley continued

Next Steps

- Travel beyond 60 miles round trip from starting location for HCBS services is not reimbursed. The HHH subcommittee will look at the impact of telehealth and potential transition to BH ARS (Behavioral Health Adult Rehabilitation Services) on this issue.
- Mohawk Valley will continue to examine data collected from the COVID-19 Remarks tracker and information shared during upcoming meetings. We will also examine and review data for potential points regarding access to tele-behavioral health in rural areas.
- Mohawk Valley C&F to perform a second round of the CFTSS/HCBS Capacity Survey in hopes of formalizing next steps as well as a formal statement for Provider/Designation List issue. This will also assist in advocacy by communicating provider capacity, sustainability, and staffing issues as well as connections to available services.

Achievements & Upcoming

- Mohawk Valley Crisis Resource List Creation & Distribution – April 2020
- Mohawk Valley- HARP, Health Home, & HCBS Reconvening – July 15, 2020
- Participating in the Southern Tier's Peer Networks Panel Event – August 2020
- Integrated Behavioral Health Virtual Event – Fall 2020

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North Country

DCS Co-chair: Suzanne G. Lavigne, MHA, CASAC II, Franklin County

Community Co-chair: Lee Rivers, Executive Director, Community Connections of Franklin County

RPC Coordinator: Karen Rappleyea

Board Membership: North Country RPC Board Members

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Meetings Held During Quarter 2

- North Country RPC Board "COVID19 Conversation" – 4/29
- C&F Subcommittee – 6/9
- Q2 Board meeting – 6/26

Q2 Top 3 Issues: Identification & Issue Development/Due Diligence

- Children & Families – Q1 Action Plan for regional, evidence-based training for staff was suspended due to NY Pause; Group agreed to do an HCBS capacity survey to address the long wait lists and difficulty getting children into needed treatment.
- NC/TH SUD Bed Finder Pilot – Difficult to find open/available SUD treatment beds. Eligible OASAS treatment providers were surveyed for participation in regional online tool for providers seeking open beds for clients.
- Housing – Behavioral health clients have difficulty accessing stable, affordable housing. Housing Workgroup formally created and drafted vision and purpose statement from workgroup feedback. Developed framework for surveys to stakeholder groups across spectrum of NC housing agencies.

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North Country continued

Next Steps

- Children & Families – Send HCBS capacity survey to 41 contacts at 17 agencies. Identify speaker(s) for next meeting on “back to school” and creative solutions in teleMH engagement with children and families.
- NC/TH SUD Bed Finder Pilot – Implementation Steps: Collect information from participating providers; work with web host to build the web page; orient & train participating providers to enter daily bed update data; present website to users (SPOAs, MCOs and OMH/OASAS programs) who will use the site to find SUD beds for clients.
- Housing – Create NC housing database. Send cohort-specific surveys to collect data on referrals, waitlists, types of housing/services, number of units, availability, and location.

Achievements & Upcoming

- COVID19 – 100% feedback from 11 North Country OMH agencies on MH Access Survey within three days of initial contact. Open dialogue with all NC stakeholder groups on successes, challenges, and recommendations on teleMH during NY Pause. North Country Crisis Resource Guide.
- Children & Families – Webinar meeting on 9/25 to have providers discuss “back to school” services with speakers from school districts.

Southern Tier

DCS Co-chair: Nancy Williams, LCSW-R, Commissioner, Broome County Mental Health Department

Community Co-chair: Johanna George, Health Home Network Coordinator, Circare

RPC Coordinator: Emily Childress

Board Membership: Southern Tier RPC Board Members

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Meetings Held During Quarter 2

- COVID-19 Open Discussion – 4/15
- Q2 Board Meeting – 5/13
- Adult Health Home/HARP/HCBS Workgroup – 6/9

Q2 Top 3 Issues: Identification & Issue Development/Due Diligence

- Medicaid recipients who rely on Non-Emergency Medical Transportation struggle to access same day transportation to OMH & OASAS clinics and appointments.
- Many agencies are unable to provide various Peer Support Services due to a lack of available peer workforce and/or inability to retain peer staff.
- Telehealth infrastructure building and utilization during the pandemic can support policy and guidance post-pandemic.

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Southern Tier continued

Next Steps

- Continue state and regional level communication and data collection regarding Non-Emergency Medical Transportation accessibility.
- A Peer Networks Panel event will be held August 24, 2020 to highlight the impactful benefits of peer networks in supporting peers in the workplace. The event audience will include working and nonworking peers and regional employers of peers.
- ST will examine data collected from the COVID-19 tracker and review potential future data collection points regarding telehealth from both provider and consumer perspective.

Achievements & Upcoming

- Southern Tier Crisis Resource Guide – April 2020
- Peer Workforce Resources – COVID-19, April 2020
- Peer Networks Panel Event – August 24, 2020

Tug Hill Seaway

DCS Co-chair: Tim Ruetten, Jefferson County

Community Co-chair: Jennifer Earl, Government Liaison, United Health/Optum

RPC Coordinator: Beth Solar

Board Membership: Tug Hill RPC Board Members

Click HERE to visit the Tug Hill Seaway RPC web page

Meetings Held During Quarter 2

- HH/HARP/HCBS workgroup – 5/6
- C&F subcommittee – 5/20
- Q2 BOD meeting – 6/11

Q2 Top 3 Issues: Identification & Issue Development/Due Diligence

- Transportation – Due to rural barriers such as lack of public transportation, limited bus schedules and routes, and limited taxi service, clients are unable to reliably receive services that require non-medical transportation.
- Adult HCBS to proposed BH ARS (Behavioral Health Adult Rehabilitation Services) transformation: Providers unclear on what this will look like for the clients and their staff.
- Children and Families – Local children's service providers have expressed concern with an increase of Residential Treatment Facility (RTF) placement requests before community resources have been exhausted.

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Tug Hill Seaway continued

Next Steps

- Continue to collaborate with Southern Tier RPC and Fort Drum Regional Health Planning Organization (FDRHPO) on the results of their transportation surveys to inform Tug Hill on their own regional transportation opportunities. FDRHPO expects to have results by August.
- Adult HCBS to BH ARS: Discuss available information on BH ARS transition at the Q2 HHH workgroup meeting. Review any information/guidance/documents that have been released at that time.
- C&F subcommittee has decided that they would like to form an ad-hoc workgroup to discuss possible solutions for premature RTF placement requests, including ways to collaborate with discharge planners at inpatient facilities.

Achievements & Upcoming

- Tug Hill COVID Resource Guide (April 2020)
- North Country SUD Bed Finder Pilot Project – in collaboration with the NC RPC- Provider Informational and engagement presentation July 15, 2020.

Western NY

DCS Co-chair: Mark O'Brien, LCSW-R, Erie County

Community Co-chair: Kirsten Vincent MS, LMHC, NYSCPS, Director of Respite Services/ Co-Manager of Care Services, Housing Options Made Easy, Inc.

RPC Coordinator: Tiffany Moore

Board Membership: Western NY RPC Board Members

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Meetings Held During Quarter 2

- OASAS 820 Residential Re-Design – 4/7
- Health Home/HARP/HCBS – 4/21
- Workforce – 4/28
- Child and Family – 5/18
- Health Home/HARP/HCBS – 6/9
- Child and Family – 6/22
- Workforce – 6/23

Q2 Top 2 Issues: Identification & Issue Development/Due Diligence

- Recruitment and retention of mental health and substance use providers continues to be a barrier that impacts delivery of services to those in need. The Workforce sub-committee is strategically looking at this issue to sustain and retain employees.
- It is very difficult to decipher the State HCBS database by county, causing increased frustration by providers when trying to determine which services are available in their county.

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Western NY continued

Next Steps

- Send a second-round survey to multi-leveled behavioral healthcare professions, investigating workforce issues to inform a future training collaborative cooperative. Initial surveys revealed potential topics including how to handle emergency situations, theory versus application, mentoring, and self-advocacy.
- The Western HHH subcommittee will recreate the state HCBS database to meet the specific needs of the area, maintained by the RPC Coordinator.

Achievements & Upcoming

- As a direct result of the work of the WNY RPC, with advisement and support from the Finger Lakes RPC, NYS DOH, OTDA and OASAS jointly issued a formal GIS notice to Local DSS Commissioners correcting the interruption of clients' Managed Care coverage when they are admitted to OASAS 820 settings.
- Survey results from the workforce workgroup yielded the Patrick Lee Foundation inviting them to present at D'Youville College on workforce retention.
- Behavioral Health Crisis Resource Guide to assist those looking for support.
- Pandemic Discussion Call – 5/22