BEFORE THE NEW YORK STATE SENATE FINANCE
AND WAYS AND MEANS COMMITTEES

JOINT LEGISLATIVE HEARING

In the Matter of the
2017-2018 EXECUTIVE BUDGET ON
MENTAL HYGIENE

Hearing Room B
Legislative Office Building
Albany, New York

February 6, 2017
1:08 p.m.

PRESIDING:

Senator Catharine M. Young
Chair, Senate Finance Committee

Assemblyman Herman D. Farrell, Jr.
Chair, Assembly Ways & Means Committee

PRESENT:

Senator Liz Krueger
Senate Finance Committee (RM)

Assemblyman Robert Oaks
Assembly Ways & Means Committee (RM)

Senator Diane Savino
Vice Chair, Senate Finance Committee

Senator Robert G. Ortt
Chair, Senate Committee on Mental Health
and Developmental Disabilities

Assemblywoman Aileen Gunther
Chair, Assembly Committee on Mental Health

2017-2018 Executive Budget
Mental Hygiene
2-6-17

PRESENT: (Continued)

Assemblywoman Linda B. Rosenthal
Chair, Assembly Committee on Alcoholism and Drug Abuse

Senator George A. Amedore, Jr.
Chair, Senate Committee on Alcoholism and Drug Abuse

Assemblywoman Ellen C. Jaffee

Senator James Tedisco

Assemblyman Angelo Santabarbara

Assemblyman Michael Cusick

Senator John E. Brooks

Assemblyman Clifford Crouch

Senator Todd Kaminsky

Assemblywoman Didi Barrett

Assemblyman Michael P. Kearns

Senator Fred Akshar

Assemblyman John T. McDonald III

Senator David Carlucci

Senator Patrick Gallivan

Assemblywoman Melissa Miller

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CHAIRWOMAN YOUNG: Good afternoon.

CHAIRMAN FARRELL: Good afternoon.

CHAIRWOMAN YOUNG: I'm Senator Catharine Young, and I'm chair of the Senate Standing Committee on Finance.

I'm joined by my colleague Assemblyman Denny Farrell, chair of the Ways and Means Committee.

And we also have several colleagues on the Senate side. I would like to introduce Senator Rob Ortt, who is chair of the Mental Hygiene and Developmental Disabilities Committee in the Senate. We have Senator Fred Akshar, Senator Jim Tedisco, Senator John Brooks, and last but not least, my colleague who is ranking member on the Finance Committee, and that's Senator Liz Krueger.

CHAIRMAN FARRELL: And we have been joined by Assemblywoman Aileen Gunther, Assemblyman Michael Cusick, Assemblyman Angelo Santabarbara, Assemblywoman Ellen Jaffee, Assemblyman Michael Kearns, and Mr. Oaks.

Good morning -- good afternoon.

CHAIRWOMAN YOUNG: Thank you, Mr. Chairman. We're a little bit maybe off-sync today because we normally start early in the morning. But it's great to be here this afternoon after the Super Bowl.

Pursuant to the State Constitution and Legislative Law, the fiscal committees of the State Legislature are authorized to hold hearings on the Executive Budget. Today's hearing will be limited to a discussion of the Governor's proposed budget for the Office of Mental Health, the Office of Alcoholism and Substance Abuse Services, the Office for People With Developmental Disabilities, and the Justice Center for the Protection of People with Special Needs.

Following each presentation there will be some time allowed for questions from the chairs of the fiscal committees and other legislators.

First of all, I'd like to welcome Dr. Ann Sullivan, who is commissioner of Mental Health. And following the

presentation by Dr. Sullivan will be Helene DeSanto, executive deputy commissioner of the Office for People With Developmental Disabilities; the Honorable Arlene González-Sánchez, commissioner of Alcoholism and Substance Abuse Services; and Jay Kiyonaga, executive deputy director of the Justice Center for the Protection of People with Special Needs.

So good afternoon, Commissioner. Welcome. We look forward to your testimony.

COMMISSIONER SULLIVAN: Good afternoon, Senator Young, Assemblyman Farrell, and members of the Senate and Assembly fiscal and Mental Health committees. I want to thank you for the invitation to explain this year's Office of Mental Health budget.

First allow me to provide a little background. As we've discussed before, the Office of Mental Health seeks to expand community services to provide better care to more New Yorkers. The goal is based upon the framework developed by the Institute of

Healthcare Improvement, which aims to optimize health system performance.

ASSEMBLYWOMAN GUNTHER: Excuse me. Can you pull that a little closer to your face?

COMMISSIONER SULLIVAN: Sure. I'm sorry. Is this better? It still echoes?

CHAIRWOMAN YOUNG: Yes.

COMMISSIONER SULLIVAN: The "Triple Aim" framework seeks to accomplish three things: Improve patient care for individuals, including quality and satisfaction; improve the health of populations; and, through these two improvements, reduce the per-capita cost of healthcare.

For decades there were few options for individuals with mental illness in the community. Inpatient care was the only readily available and standard option. Unfortunately, it was not the best option for many people. In the years since institutionalization was the norm, mental health care has evolved so that individuals

need not spend their entire lives as an inpatient, but can successfully live and work in their communities.

Through your continuing support of reinvestment, our efforts to provide individuals with mental illness the right service at the right time in the right setting have started to bear fruit. With a commitment of more than $81 million thus far, we have been able to provide services to more than 20,000 new individuals through December 2016. This includes new supported housing for more than 900 individuals; state-operated community services, including crisis residences and mobile integration teams that have served an additional 6,900 individuals; and a wide range of locally operated community-based programs, including peer crisis respite, first-episode psychosis, community support teams, and Home and Community-Based Waiver services for more than 13,000 individuals.

Because these community services are now in place, we are able to provide

inpatient services when needed, and also assure the necessary outpatient care and supports are available when an individual is discharged. Our ability to serve more citizens of the state has increased through the combination of these improvements to new and existing services.

The fiscal year 2017 Executive Budget priorities. Next I will move to what we plan on doing this coming year. For the next fiscal year, OMH will continue on this path towards greater access to community-based services, targeted at each individual's particular needs. Importantly, the 2017-2018 Executive Budget proposes to:

(1) Continue the investment in community services. The budget adds another $11 million, annually, to expand capacity in less-restrictive, more-integrated community-based settings. This amounts to an annual investment of $92 million since fiscal year 2015 to expand community mental health services based on OMH inpatient savings.

(2) Fund 280 additional supported

housing community beds. OMH will reconfigure 140 state-operated residential beds, which are less integrated and more costly to operate, and replace them with funds to develop 280 community-based, scattered-site supported housing units in the same geographic area. These new units, when provided in tandem with access to other existing community services, will ensure the continued support and care of all individuals transitioning into less-restrictive settings, while keeping them close to their families.

(3) Provide $10 million to enhance support for existing residential programs. The budget increases funds for supported housing and single-resident-occupancy programs. This investment will help preserve access and maintain existing housing capacity as the state brings new housing units online through the Empire State Supported Housing Initiative.

In this year's budget we continue investing in the implementation of Medicaid managed-care initiatives for adults and

children. Key accomplishments and initiatives include:

Increased HARP enrollment. Almost 80,000 people are currently enrolled in Health and Recovery Plans (HARPs), the state's behavioral health specialty managed-care product, approximately 45,000 in NYC and 34,000 in the rest of the state;

New ACT Teams. Funding for 20 new Assertive Community Treatment teams offering targeted help for homeless and high-need individuals in need of intensive behavioral health services;

Managed care for youth. A commitment to integrate children's behavioral health services into managed care, including the expansion of six new state plan services for children and continued support for the operation of a comprehensive Home and Community-Based Services network.

Lastly, as I noted earlier in my testimony, improving patient care and the health of our population will save the state money. OMH's strategy to achieve this goal

is through the development of targeted community services to assist individuals in their communities and hopefully intervene with these services in order to avoid the need for inpatient hospitalization.

For those individuals who continue to occasionally need inpatient hospitalization, New York State has the largest number of psychiatric inpatient beds available in the nation, and we will continue to preserve access to inpatient care as we work to transform the system.

Again, thank you for this opportunity to address you on the 2017-2018 OMH budget, which supports and continues the work we have begun to transform New York's mental health system. Thank you.

CHAIRWOMAN YOUNG: Thank you.

We've been joined by Senator Diane Savino.

ASSEMBLYMAN OAKS: We've been also joined by Assemblywoman Miller.

CHAIRWOMAN YOUNG: Thank you.

Our first speaker will be Senator Rob

Ortt, chair of the committee.

SENATOR ORTT: Good morning, Commissioner. How are you?

COMMISSIONER SULLIVAN: Good morning -- afternoon.

SENATOR ORTT: I want to thank you for joining us. I certainly appreciate your testimony this morning and your presumed forthright answers to all the questions that will be coming your way.

You and I have spoken significantly over the past two years about the Western New York Children's Psychiatric Center, and I guess I wanted to start off by asking, so where is that today? Where are we in the process of the planned merger -- the closure of Western New York Children's and the merger with Buffalo Psychiatric Center?

COMMISSIONER SULLIVAN: At this point in time, we are still continuing to work on and review the plan to move Western Children's to relocate to Buffalo. I think you're probably aware that a bid did go out for the construction for Buffalo. And those

bids will be received in February and reviewed. So at this point in time we are still in the process of continuing moving towards that goal.

SENATOR ORTT: And you and I have had back and forth discussions on this. But, you know, one of the main arguments that I've heard from families and from advocates in both my district and across Western New York is that several years ago, Western New York Children's in West Seneca was created because there was evidence, clinical evidence to suggest that separating children from adults, having them on a separate campus, having them I think specifically on that campus, was much more conducive to their rehabilitation and to providing them the treatment and services that we know we need in children's mental health.

So I guess has something changed clinically or has something shifted that makes merging it with the Buffalo Psychiatric Center a -- the right move from a clinical or service standpoint?

COMMISSIONER SULLIVAN: There are many models, actually, of children's psychiatric services. Sometimes children's inpatient services are collocated within the same building as adult services, sometimes they are in separate facilities, sometimes they are within facilities but right next door to adult services.

So the model has taken various forms over the years. In 1968, when West Seneca was established, I'm assuming a decision was made that it made sense at that point in time. The length of stay in those days was much, much longer in children's facilities. The average length of stay today is about two months, which is probably just a little bit longer than some of the acute-care services, which is sometimes like a month's stay. And they are right next to, sometimes in the very same building as adult care services.

So the models differ. But the literature today is really showing very strongly that if you have the right community-based services, that that's the

key. Because really we should only be having youth in hospitals when it's absolutely necessary.

So the plan for West Seneca in terms of moving it was to enable us to put those community services in place for like a thousand youth.

I do not believe there will be any diminishing of the quality of care. The same clinical team will move. We will have the same number of beds. The new facility is designed to be separate, both separate entrances, a separate recreational area for youth. And I have seen facilities located like that that provide excellent care. So I don't think there will be any diminution in care, and it enables us to invest in community services.

SENATOR ORTT: Would you agree that the data shows that the outcomes currently at Western New York Children's are the best of any state children's psychiatric center?

COMMISSIONER SULLIVAN: They have great outcomes, yes, they do. We're very

proud of them for that.

SENATOR ORTT: Right. So the model -- it would be wrong to argue that the model in West Seneca is not producing the desired outcomes.

COMMISSIONER SULLIVAN: I think those outcomes are more to do with the clinical programming and the clinicians who are at the -- not to say that my clinicians at other sites aren't also excellent. But the clinical program which has been developed along -- for quite a while and has very innovative approaches, I don't believe that that quality will diminish in the new setting.

SENATOR ORTT: What is the estimated savings?

COMMISSIONER SULLIVAN: The estimated savings is about $3.5 million annualized, of which we've already invested about a million and a half in the community services.

SENATOR ORTT: And what's the total cost of the build-out?

COMMISSIONER SULLIVAN: There are

actually two numbers. The cost to do the build-out in Buffalo will be about $12.5 million.

SENATOR ORTT: It's never good to have two numbers, just as an accounting rule.

COMMISSIONER SULLIVAN: No, no, I meant to say there were two numbers on the -- for West Seneca. One is short term at West Seneca, which would be probably somewhat comparable, in the range of $12 million to $14 million.

But West Seneca is a building that is also -- hasn't really been refurbished in basic infrastructure since -- for many, many years. So there's another price tag on capital, which would increase another $40 million to bring it up to what it would need to be if you were to stay at West Seneca indefinitely. That was the one I was talking about. The numbers are the -- only one number for Buffalo.

SENATOR ORTT: Are there registered sex offenders currently in BPC?

COMMISSIONER SULLIVAN: Yes. At the

time that we -- there would be no, and this is an absolute commitment, there would be no registered sex offenders at BPC at the time we would move children. And it's about a two-year -- if this goes forward, about two years. So we have time to move all -- any individuals who are from Buffalo. And we would not ever have them again.

SENATOR ORTT: So it's your commitment to the parents and everyone here in this room that you would move those individuals --

COMMISSIONER SULLIVAN: Yeah, absolutely. Absolutely.

SENATOR ORTT: Moving to, I guess, broader children's health, children's mental health, it's my understanding the proposed savings on the children's side in the current budget is because of delayed implementation of Medicaid redesign proposals, is that accurate?

COMMISSIONER SULLIVAN: Yes. Yes.

SENATOR ORTT: If the focus is on redesign to expand capacity and access to services, it's been under design, I believe,

for four years?

COMMISSIONER SULLIVAN: Yes -- I'm sorry, I didn't understand --

SENATOR ORTT: It's been under design for approximately four years, right?

COMMISSIONER SULLIVAN: Yes. Yes.

SENATOR ORTT: Now we're saying we're going to have to wait another year for services. Don't you think there's a need to invest in some of these crisis services today while we wait for the federal side to get their act together?

COMMISSIONER SULLIVAN: Well, just to explain a little bit, the commitment on the part of the Department of Health and the Governor to expand children's services is considerable. So when the expansion happens, which means when we begin the services for the six new SPA amendments and other waiver services, it's estimated that it will be up to $30 million additional investment for SPA and $30 million additional investment for children's services for waiver services.

So that's $60 million. That's not

predicated on any savings, that's pure expansion. So that money is still there, and that money will happen.

However, it is also true that because of a delay, largely because of some of the uncertainty at the federal level, children's managed care will not happen until October of this year, and the SPA services until July. So there is a period of time to save dollars from those projected expansions.

And yes, those dollars have been used to assist DOH in dealing with some of the global cap issues.

SENATOR ORTT: Has OMH developed a plan for how to spend the $10 million in subsidies for housing?

COMMISSIONER SULLIVAN: Yes. Yes. And that will enable us to try to bring closer to the need the already existing supported housing. We'll probably be adding about $500 to the subsidies in downstate. And for SROs, which is single-room occupancies, a little over 600 upstate and a little over 700 downstate.

This is important because to find apartments now, especially in certain parts of the state, is extremely difficult. Our distribution of the dollars is based on HUD market rate and the difference between the cost of an apartment and the difference between the subsidy and HUD market rate. So that's how we decide where to put the money.

SENATOR ORTT: Commissioner, under the current budget, how many state-operated outpatient clinics would be closed?

COMMISSIONER SULLIVAN: Truthfully, I don't know.

What we're going to be doing is looking at, across the board, all the state clinics. We're doing what I think every other healthcare system is doing, looking at our efficiency, looking at our productivity, looking at if there's anywhere where there's duplication of services or services could be better designed.

So we will start that process, after the budget, to look at those clinics. We will decide which ones may be appropriate for

closing. Some may be consolidated, some may be enhanced. I mean, we need to look at the needs in the community. It will be a process that will involve community as well as us -- we're not doing this without input from the communities where our clinics are.

And even if a clinic were not all that productive, if it is the only clinic there -- which we have in some in parts of the state -- that clinic will remain. Our major focus is to make sure access is preserved, and we will not in any way close any clinics where we have any question that access would be impaired.

SENATOR ORTT: Thank you, Commissioner.

CHAIRWOMAN YOUNG: Thank you.

Chairman Farrell.

CHAIRMAN FARRELL: Aileen Gunther, chair.

ASSEMBLYWOMAN GUNTHER: The first year I was chair of this committee, the Executive Budget included Regional Centers of Excellence, a plan to close and consolidate

state-operated mental health facilities. We held hearings across the state and were successful in negotiating compromises that held for a number of years. OMH can close a bed only after it has been vacant for 90 consecutive days. And when a bed is closed, OMH will invest $110,000 per closed bed into community-based services.

Yet now I see in the Executive Briefing Book -- and this has to do with Hutchings -- a proposal to transfer operation of the children and youth beds from Hutchings to a yet-to-be-named hospital, though we do hear some rumors. To the best of my knowledge, there is no information in the Article VII bills and no information anywhere else on the motive and the means for transition, with the exception of an anticipated savings of $900,000.

What is the impetus for this? Why is this happening?

COMMISSIONER SULLIVAN: First of all, these are very -- I have to say these are still very preliminary discussions with SUNY

Upstate.

The impetus for it is that basically at this point in time we have a census of about 23 children that we can accommodate at Syracuse. In that area of Syracuse, with the work -- talking with Syracuse, Upstate University, it looks like we could -- they would be committed to possibly enhancing that to a count of about 30 beds that would be available.

One of the issues in that area is commercial insurance, commercial insurance for youth. There are no other child beds in this area, and the commercial insurance has always, traditionally, been very reluctant to enable individuals under commercial insurance to be hospitalized at state hospitals. So part of the impetus for this is to expand the availability of children's beds to the wider community. That will not only include Medicaid, but will include commercial payers.

Also, Upstate has a wonderful reputation with children's services and I think, as an academic institution, could help

us recruit. Recruitment is always an issue, both for psychiatrists and nurses anywhere. I think it will help with that as well.

Also, they have some very innovative ideas about programming, et cetera.

So I think this is a move that could really benefit the community and the children. And it's very preliminary, and that's why we're putting it out there now, so people know that these are under discussion. There will be no decrease in services; in fact, there's a possibility of an expansion of the beds.

ASSEMBLYWOMAN GUNTHER: So one of the issues is the recruitment of registered nurses because of the level of pay right now and --

COMMISSIONER SULLIVAN: Yes.

ASSEMBLYWOMAN GUNTHER: And so if it's SUNY or -- so that there would be an increased level of pay to registered nurses, and that would be more of an encouragement to come and work?

COMMISSIONER SULLIVAN: Yes.

ASSEMBLYWOMAN GUNTHER: So you reenvision the location of all these services. Let's imagine, for the sake of argument, that on Monday the operation of these 30 beds is transferred to SUNY Upstate. We're just using that, we're not sure yet. On Tuesday, SUNY Upstate decides to close these beds. It seems to me that this could be the scenario. OMH has just saved itself $3.3 million in community reinvestment, and the community has lost access to critical beds.

What are you doing to prevent this scenario?

COMMISSIONER SULLIVAN: Throughout the state, whenever there is an attempt or an interest in closing beds, that has to come before the Behavioral Health Services Council and then ultimately before the Health Planning Council, and there has to be -- there are hearings and basically there is input, considerable input from OMH.

So we have had this issue for a variety of issues. Sometimes it's a clinic,

sometimes it's inpatient beds. And if those beds were needed, we would do everything possible to keep them open, and we've been successful in keeping them open against pressures, at times, from voluntary institutions.

ASSEMBLYWOMAN GUNTHER: Just on a side bar, I know that, you know, as far as my Assembly district, it's very, very long. And we had a call from a mother who the child had suicidal ideation. And we called Rockland Psych; to get an inpatient, there was -- we called Four Winds, we called Rockland Psych, and we couldn't get that child placed.

So the mother, who had three other children, had to sit with this child, because of the suicidal prior attempt, for close to -- for two to three days before she ever got a bed.

So, you know, sometimes I'm like kind of confused when I get calls like that personally -- and also people know that I'm the chair and I have a lot to do with mental health. But there are children waiting in

the wings. I know, representing Sullivan County, how many pediatric beds we have, I know how many pediatric beds are at Four Winds and the catchment areas.

So I think when a child has suicidal ideation -- and we are recognizing those diagnoses much earlier than you and I when we were in a hospital situation.

COMMISSIONER SULLIVAN: Mm-hmm. Mm-hmm. Mm-hmm.

ASSEMBLYWOMAN GUNTHER: So, you know, sometimes it's -- I don't understand. And, you know, when we talk about the outside, the community -- you know, if -- and in some areas, maybe New York City. But you travel to the middle of upstate New York, and you know what, the psychiatrists are few and far between, our department of healths, our community departments of health don't have much money to have a psychiatrist, social workers. They're few and far between. Even our schools have very few.

And I think that the closure of beds -- and sometimes when a child is in

crisis, they need that inpatient stay. And also I think it not only educates the child, but it also educates the parents on what to do when you leave that facility.

So we're doing a lot of closures at this point, and I just -- you know, I want to know about the community reinvestment. I know that we talk about it, but I like nuts and bolts. That's what I'm all about. Like exactly where is the money going, and exactly how are we going to deal with the increase in the diagnosis and the incidence of mental health? And we all know it takes a lot of years.

And now people are talking about a lot more, but -- we have an increase, but yet we're not -- we say we're increasing in the community, but there's other people out there that I'm not really feeling it.

COMMISSIONER SULLIVAN: Well, the increase in services from reinvestment has really been considerable. We've instituted about -- an additional 250 home-based crisis service waivers. So we've increased

home-based crisis waiver services. That's the most intensive outpatient, home-based services.

We've also opened up four respite centers. We've increased mobile crisis capacity for children and youth. And we've increased clinic slots across the state. And there's a whole breakout of exactly where this has happened and where the dollars have been invested.

If you put the right kind of community services out there, it doesn't mean you need an inpatient bed, by any means. But you certain can decrease the number of inpatient beds that are necessary, and you can often reach more people in the community.

So these services are real, they are up and running for kids. And I think we can give, you know, the listing of exactly where they are. That's in the report, so we can show exactly where those services are.

And of the reinvestment dollars, at this point in time $61 million is actually being spent serving those additional 20,000

individuals, and we've allocated $69 million. So the other $8 million is out there to be actually implemented within the next year. But these services are real and they're going out.

And sometimes it can also take a little time for the community to readjust a little bit with the services and inpatient beds. But yes, you're right, that when a child needs an inpatient bed, it should be there.

ASSEMBLYWOMAN GUNTHER: Really quickly, we have a $5.5 million community reinvestment. Where has it been invested?

And the other thing I wanted to know is about the reduction of the OMH underutilized and low-performing clinics. What's happening with that?

COMMISSIONER SULLIVAN: Well, the clinics, we haven't -- we're going to be looking at all our clinics.

We're actually -- when we've done a very brief across-the-board look, it's looked like some of our clinics are underproductive.

So now we're going to be delving down into it to be sure, and we're going to be making sure that if we do any changes in the clinic structure, it's to make it more efficient and more accessible to our clients.

So nothing has been done yet. We're going to begin looking at that and studying that right after the budget.

ASSEMBLYWOMAN GUNTHER: Thank you.

CHAIRWOMAN YOUNG: Thank you.

CHAIRMAN FARRELL: Thank you.

CHAIRWOMAN YOUNG: Thank you, Commissioner.

Just a few questions. So you referenced -- you talked a little bit with Senator Ortt and with Assemblywoman Gunther about the 85 clinics, and you said you don't know whether or where certain clinics would be closing.

COMMISSIONER SULLIVAN: Right.

CHAIRWOMAN YOUNG: So there's this administrative action proposed by the Governor. But if there were clinics that were deficient, underperforming in the past,

why weren't they dealt with, and why now this wholesale approach?

COMMISSIONER SULLIVAN: Well, actually -- it's a good question. I think that we have known for a period of time that perhaps our clinic system could be more efficient. I think we've been preoccupied with dealing with lots of other things, including some of the reinvestment transitions on the adult side. And so we have started to look at the clinics.

I think that, you know, our clinic system serves very complex patients and some seriously mentally ill patients. But we also have a wide network of community-based clinics out there also that can sometimes serve the same population. So we're looking at it. We're looking at it at --

CHAIRWOMAN YOUNG: Excuse me, Commissioner. Are you looking, then, to shift services provided by the state to these nonprofits? Is that the plan?

COMMISSIONER SULLIVAN: Not particularly, no. There might be some areas

where, if we were to close or reduce the clinic, we would be confident. We wouldn't do that unless we were confident also that there were enough services in the area. And some of those services we will be looking at will also be the community-based.

CHAIRWOMAN YOUNG: So you and I have had many, many discussions about lack of mental health services across the state. There are places that are totally underserved. There are so many people who have mental health concerns who can't get treatment, and they may be in an urban setting, they may be in a suburban setting, they may be in a rural setting. And so, you know, I get a little bit concerned when I think about the possibility of actually losing services that are being provided right now.

So in the event there are clinic closures, what would be done to make sure that there isn't any loss of access? Because access is key.

COMMISSIONER SULLIVAN: Absolutely.

CHAIRWOMAN YOUNG: Actually, we need to expand mental health services, in my opinion.

COMMISSIONER SULLIVAN: We'll be working with the communities where the clinics are. And we'll be working with the local government units, we'll be working with the providers in those communities. And if there's any question that we cannot close the clinic or reduce the size of the clinic because of access issues, we will not.

CHAIRWOMAN YOUNG: Okay, thank you.

Now, also in the Governor's proposal he's looking to reduce the number of state-operated residential beds by 140 and replace them with 280 community-based scattered-site supportive housing units. And we've talked a little bit about that today also.

But does this represent kind of a future trend of shifting these state-operated services into other nonprofit providers? And you kind of said no, there was no plan with the 85 clinics. But is there a plan with

this FTE reduction?

COMMISSIONER SULLIVAN: I think it's a different issue with the housing. There have been federal moves, on something called Olmstead and others, that basically individuals with mental illness should be in the community.

These institutions -- I shouldn't call them institutions. These residences are very institution-like, so they are really not embedded in the community. So for good clinical reasons, it makes sense to -- if we can -- move some of those beds into the community so individuals can be fully integrated.

Also, it's more economical. But it also serves to really fulfill some of the federal mandates to kind of be moving individuals who have spent a long time on our campuses in housing out in the community.

For the 140 beds that we will close, we will be able to open up 280 supported apartments with the services that individuals need and really help integrate them more into

the community.

CHAIRWOMAN YOUNG: Thank you.

Switching gears now a little bit, the Governor proposes increasing collaboration between OMH and DOCCS, the Department of Corrections and Community Supervision, in the treatment of sex offenders. And the Governor anticipates that this will result in sex offenders completing treatment programs before the end of their prison terms, resulting -- theoretically -- in a decrease in the transfer of individuals to OMH secure facilities for treatment. So I have a couple of questions about that.

First one, how does the current treatment protocol for sex offenders in the correctional facilities compare to the treatment of these same individuals in OMH facilities?

COMMISSIONER SULLIVAN: The basic clinical structure of the kinds of groups, the cognitive work, et cetera, will be the same. Basically, these individuals have -- in the past would have waited until they were

leaving prison to then be examined to decide whether or not they needed to go into civil commitment. We're now moving, in essence, the same kind of programming into the prison so those individuals, if successful, may not need to go to civil commitment. They are still evaluated at the point that they would be leaving their sentence, whether or not they would need to go to civil commitment.

CHAIRWOMAN YOUNG: So you're saying that DOCCS' treatment protocols are different than OMH's right now, but you're looking --

COMMISSIONER SULLIVAN: No, they're very similar. They will be very similar. They will be very similar. There's some difference --

CHAIRWOMAN YOUNG: They will be, but you're saying they're different now?

COMMISSIONER SULLIVAN: No. Basically, this kind of intensive treatment for sex offenders is not there right now in the prison system.

CHAIRWOMAN YOUNG: That's my question.

COMMISSIONER SULLIVAN: Yes.

CHAIRWOMAN YOUNG: So it's not there at DOCCS right now, so how will it get --

COMMISSIONER SULLIVAN: Well, we've already -- I'm sorry, it is there. We've started with the special prisoner-based program. That has started, and we will be expanding it. But before that, it was never in DOCCS. So it's been about a year and a half or so. Before that, it was never in DOCCS.

CHAIRWOMAN YOUNG: Okay. Thank you. So currently there is a statutory process where certain sex offenders nearing the completion of their prison term are assessed for risk and for mental abnormalities. And I know you're very familiar with that.

Under the Governor's proposal, will prisoners in the DOCCS system who have completed their treatment program and who are pending release from prison undergo an assessment from OMH to determine whether there's a need for referral to the New York State Attorney General to seek civil management?

COMMISSIONER SULLIVAN: Yes.

CHAIRWOMAN YOUNG: There will be.

COMMISSIONER SULLIVAN: Yes.

CHAIRWOMAN YOUNG: Could you expand on that, please?

COMMISSIONER SULLIVAN: Basically, they will have the same examination done as they would have had had we not had that program in the prison. So everyone who would leave would still be examined by one of our qualified psychologists and psychiatrists to determine whether or not civil commitment is necessary.

CHAIRWOMAN YOUNG: Okay, thank you.

And finally, I wanted to ask about telehealth -- and as you know, I've been very involved in bringing telehealth services across the state -- but expanding it into telepsychiatry, because, as we spoke about earlier, it is so crucial to get more services into the communities for people with mental health concerns.

Could you tell me about what's going on at the agency right now?

COMMISSIONER SULLIVAN: Yes. Thank you so much for your support for this. It's really wonderful, and we're very excited and engaged in expanding telepsychiatry across the state. We have reviewed the regs so now telepsychiatry can be billed in multiple settings through Medicaid.

Basically, our clinics, we have several clinics in -- OMH clinics in the rural areas where we are doing telehealth. There are several -- through DSRIP, we have a number of emergency rooms who are taking on telehealth, so that basically individuals can be examined remotely in the emergency rooms, helping to make decisions about admission or discharge.

We have looked at the -- we are looking at telehealth for nursing homes, to be able to kind of do evaluations.

So I think we're looking for telepsychiatry in just about every area that it could be utilized. The science shows that it is just as effective as having face-to-face interviews, especially for

consultations and evaluations. And we are also looking at it for ongoing treatment. In certain clinics we're beginning to pilot so that telepsychiatry can be a psychiatrist who would continue to see, through telepsychiatry, a client on an ongoing basis.

So we're very excited about expanding telepsychiatry across the state.

CHAIRWOMAN YOUNG: Great. And so I have partners in the Assembly who are very interested in expanding telepsychiatry. So we do have legislation, but we'll be talking to you about that in the future.

COMMISSIONER SULLIVAN: Great. Thank you.

CHAIRWOMAN YOUNG: And I do want to, finally, associate myself with the strong support that was displayed by Senator Ortt in keeping services constant, the way they are, at the Western New York Children's Center. I think that is such an important issue. And you've been in discussion with us now for a couple of years about it, but our position hasn't changed. And we believe very strongly

that things should not change in the manner that -- moving it to the BPC. And I just want to reaffirm that.

So thank you very much.

COMMISSIONER SULLIVAN: Thank you.

CHAIRMAN FARRELL: Thank you.

We've been joined by Mr. McDonald.

Next, Mr. Kearns.

Oh, and Didi Barrett is here. I'm sorry, there she is.

CHAIRWOMAN YOUNG: And, Mr. Chairman, I'd like to point out -- I just noticed that we've been joined by Senator David Carlucci.

ASSEMBLYMAN KEARNS: Thank you, Mr. Chairman, for giving me this opportunity today.

Thank you, Commissioner. I'll be brief with my remarks.

As you know, we've been talking about the Western New York Children's Psychiatric Center for over three years. And I want to thank the chairman of our Assembly committee for coming out to Buffalo and doing an excellent job in meeting with the parents and

advocates.

Recently, I sent out a survey and within three weeks, I've received 1200 responses. And what I can't understand is why we are doing this. Why are we trying to fix something that isn't broken? The community, the professionals, going back to 1965, the New York State Planning Committee stated that the units for children should be separated from the mainstream of adult patients in separate buildings or cottages.

But my question is this. One of the things that they're concerned about, especially the families, is the safety of the children going into these facilities. So if you could just answer this one question: Right now, how many adults convicted of sexual assault are housed at the Buffalo Psychiatric Center, as we move those children and close down that facility in West Seneca, which has been rated one of the top facilities in the state, the lowest reinstitutionalization rate?

The Western New York delegation -- why

are we doing that? And if you can answer that question, currently today, right now, how many convicted sexual predators are within that facility?

COMMISSIONER SULLIVAN: Right now there is one sexual predator -- one person convicted of sexual -- inpatient in Buffalo Psychiatric.

ASSEMBLYMAN KEARNS: Were any moved prior this year? How many were there this year? Were any --

COMMISSIONER SULLIVAN: I believe we had four. So we have moved three.

ASSEMBLYMAN KEARNS: And will any be able to have access to that facility, even on an outpatient basis?

COMMISSIONER SULLIVAN: Yes. There are some -- I think there are four on an outpatient basis. And basically our commitment, and I truly -- this is an absolute commitment -- is that none of those individuals will be there in the event that we move West Seneca to Buffalo.

ASSEMBLYMAN KEARNS: I just want to go

on the record and I want to thank the chairman for giving me this latitude of speaking on this issue on behalf of the Western New York community, on behalf of the families.

I could read testimony after testimony of people that don't want this facility closed. You know that. I just think it's an abomination. I had an opportunity to ask the Governor himself. And my final question is, have you asked the Governor -- is the Governor aware that this facility is going to be closing?

COMMISSIONER SULLIVAN: The Governor's office has been briefed about this. And I am charged with bringing to the Governor -- to discuss all your concerns that have been stated over the various periods of time. So I will be discussing those concerns, and they will be reviewed with the Governor's office.

ASSEMBLYMAN KEARNS: The Governor himself?

COMMISSIONER SULLIVAN: With the Governor's office.

ASSEMBLYMAN KEARNS: The Governor himself?

COMMISSIONER SULLIVAN: It's my understanding, when I hear from the Governor's office, that that is my -- that's the place I speak to. So with the Governor's office.

ASSEMBLYMAN KEARNS: Well, thank you, Mr. Chairman, for that, for giving me that time.

I just want to leave you with this, and I hope you remember. There's a road going into that facility called Hope Way. And when the kids leave, after leaving, they leave their handprints on the wall and they leave encouragement for future people. Just think of that as we go forward and we discuss this issue.

COMMISSIONER SULLIVAN: Thank you.

ASSEMBLYMAN KEARNS: Thank you.

Thank you, Mr. Chairman.

COMMISSIONER SULLIVAN: And I do appreciate your concerns. But just to state one more time, that our goal here is to

really serve even more individuals in Western New York. A thousand additional families could be served. I just wanted to just emphasize that. Thank you.

CHAIRWOMAN YOUNG: Thank you.

Senator Akshar.

SENATOR AKSHAR: Commissioner, welcome. It's always good to be in your company. Welcome today.

I want to bring you to the Southern Tier; specifically, to the Greater Binghamton Children and Youth Services. The last time we spoke, you said there were no plans to reduce the amount of bed space. And I see in the Executive's proposal this year, in 2017, there's a plan to reduce the bed space by three.

Can you just explain to me what has changed, so I can properly represent your position, and the Governor's, to the constituency that I serve?

COMMISSIONER SULLIVAN: Thank you.

Basically, whenever we've reduced beds -- and that includes the beds in

Binghamton -- it's by our agreement with the Legislature, that those beds have been vacant for 90 days. I think when we were there, we didn't have any beds that were vacant for 90 days. When those beds do become vacant for that period of time, we do close the beds.

But we're doing it very gradually. If we should notice that at some point we needed to reexpand those beds, we would. But at this point in time, we have not had to expand or replace those beds. They've been staying vacant. So there was a difference at that point.

SENATOR AKSHAR: So currently the need is not there?

COMMISSIONER SULLIVAN: Currently the need is not there, yes. Thank you.

SENATOR AKSHAR: You made a reference a few minutes ago to in making decisions you look at the economics of it, right, in making those decisions. And from a macro perspective, help me understand when we're talking about savings and reinvestment, in

your mind, the savings that we find, are we properly reinvesting those dollars into the system?

Because clearly there is a need to provide mental health services throughout this great state. And I would respectfully offer, to something Senator Young said a few minutes ago, we need more of it. So in your mind, are we properly reinvesting those dollars?

COMMISSIONER SULLIVAN: Yes, I think we are. And we're not doing it in isolation. All the reinvestment planning has been done with the local communities and with the LGUs in those areas. So, for example, a lot of the reinvestment has gone towards supported housing, which individuals who are leaving the psych centers, that decreases the need for beds because our patients don't have to wait as long in the psych center to get the housing.

We've also opened up, for children, respite beds. For adults, we've also done a lot of mobile crisis work. When you have a

mobile crisis team or a mobile integration team that wraps services around an individual, that can avoid admissions, and avoid admissions both to the state but also to the voluntary hospitals. So it really enables us to enable those beds to close because we have the right services, including clinic services, which have expanded also in some areas.

But those crisis mobile integration teams and the ability to have the right housing for individuals has made a significant difference in our ability to have less inpatient beds. Individuals who are better can now leave sooner and get into apartments and have the services they need wrapped around them and not get readmitted.

SENATOR AKSHAR: So the reinvestment in terms of the services is from a global perspective --

COMMISSIONER SULLIVAN: Yes, it is.

SENATOR AKSHAR: -- it's ensuring that we're paying the staff the appropriate amount of money so they can continue to work and

provide the service that the people need, and that the beds are there and the facilities are there.

COMMISSIONER SULLIVAN: Yes. Yes.

SENATOR AKSHAR: Thank you, Commissioner.

CHAIRWOMAN YOUNG: Thank you, Senator.

CHAIRMAN FARRELL: Didi Barrett.

CHAIRWOMAN YOUNG: Before that, I would like to announce that we've been joined by Senator Todd Kaminsky.

Thank you.

ASSEMBLYWOMAN BARRETT: Hello. As you probably know, I have in my district the Hudson Correctional Facility, which is now the younger facility for 17-year-olds and 18-year-olds.

I'm wondering -- we had a visit recently there. I was pretty alarmed to see that they have a solitary program there which -- in fact, the young man that was in solitary had come directly from a psych facility. I'm wondering how much you're working with that population or intend to be

working with that population to make sure that mental health services are a significant and robust part of that program.

COMMISSIONER SULLIVAN: We are working very closely to make sure that the right mental health services are there and to evaluate the needs of the individuals that are there, and to hopefully have the use of solitary as little as possible.

I think that we had received funding and planning and we're continuing to look at what kind of innovative services we could put there to really make a difference in the lives of these youth. So yes, we are looking at it very closely, and we will continue. It's still a relatively new program, but we are invested in these youth because it's a critical point in their lives.

ASSEMBLYWOMAN BARRETT: And it's sort of hard to imagine that anybody who's dealing with emotional issues and isn't an adolescent, basically, which is what they are, it would be appropriate for them to be in solitary. Do you have a position on that?

Have you --

COMMISSIONER SULLIVAN: You know, I think the use of solitary is really something that the Department of Corrections is very -- we have not taken an absolute position. But clearly, we would want to keep as many individuals out of that environment as possible.

ASSEMBLYWOMAN BARRETT: Well, especially when you're focusing on a program that's addressing youth, and youth in this stage. And, I mean, mainstream, normal, healthy, if there's such a thing as -- adolescents, you know, act in a lot of impulsive ways. So it just was astonishing to me to see that going on there. And I would encourage you to sort of be as active and engaged in that facility and making sure that that is used as little as possible.

COMMISSIONER SULLIVAN: Yes, we will. Thank you.

ASSEMBLYWOMAN BARRETT: Thank you.

CHAIRWOMAN YOUNG: Thank you.

Senator Brooks.

SENATOR JACOBS: Commissioner, could you address any initiatives in the plan that you have as far as veterans who are in need of mental health services?

COMMISSIONER SULLIVAN: Yes. You know, throughout our system, actually, our entire clinic system across the state, we serve about 20,000 veterans in various pieces of our service system.

But we also do a lot of training of clinicians, because working with veterans requires a special skill set. So the department has done a lot of training with staff across the state to work on that.

And then we have also begun to have some of our housing dedicated to veterans with serious mental illness. And I was just at a lovely opening on Long Island for housing really specially earmarked for veterans with serious mental illness.

And also, in our research institutes, we are continuing to do work on how to spread good practices for the treatment of PTSD.

So I think we are trying to do a great

deal for veterans. I think you can always do more. But we do have them involved in many ways in our system of care.

SENATOR BROOKS: Okay, thank you.

CHAIRMAN FARRELL: Assemblywoman Jaffee.

ASSEMBLYWOMAN JAFFEE: Thank you, Commissioner.

A question in general. One of the things that I hear on a regular basis in the community is lack of psychologists, access to counseling, social workers that provide assistance in terms of mental health. And this is a major issue for our communities.

And for instance, I was approached regarding the mental health issues for a kindergarten child. And in Rockland County -- and I understand this is in general, throughout the state, there are areas -- there was not one psychologist that could respond to the needs of that child. We had to reach out into New York City to see if we could find some staff, somebody who could respond and assist the family and the child.

This is a very serious issue throughout the state, not just in Rockland County, because I've reached out to inquire. Can we put forward some initiative, some effort to encourage our youth to move into that area of psychology, encourage our SUNY schools to provide that kind of training? Can we put together a financial initiative to be able to encourage them to move forward in those areas, perhaps, you know, beyond their college degree to a master's or a Ph.D.?

We need to provide that support for our children and our communities, our families. So I just wanted to raise that as a really major issue.

COMMISSIONER SULLIVAN: Thank you very much. I think the workforce issue is critical in mental health. And it has -- I obviously agree with you that we don't have enough individuals going into the training and then coming out of the training. So I obviously agree with you, I think we will be very happy to kind of consider workforce.

You know, we recently, with one of our

state psych centers, are working with Mercy College to have some of their students kind of rotate through our services. So, for example, a social worker might then pick mental health versus something else that a social worker could be involved with. And I think we have to do much, much more of that. We have to expose students to the wonderful work that you can do in mental health. Often they don't even get to see it, and so they choose other things.

So I absolutely agree with you. I think it's a critical workforce issue and something that the whole nation is facing. And I think working with the universities is very important, and we'll be glad to work on that.

ASSEMBLYWOMAN JAFFEE: So maybe we can work together and get this moving forward. I will reach out.

COMMISSIONER SULLIVAN: Yes, that would be terrific. Because I do think it's -- and incentives, I think, do help. So we should talk, we should work and see what

we can do. That would be terrific. Thank you.

ASSEMBLYWOMAN JAFFEE: Okay, thank you.

CHAIRWOMAN YOUNG: Thank you very much.

We've been joined by Senator Patrick Gallivan. And just so every Senator knows what the order is, next is Senator Kaminsky, then Senator Carlucci, and then Senator Gallivan.

So Senator Kaminsky.

SENATOR KAMINSKY: Thank you. I really want to echo Assemblywoman Jaffee's comments on workforce development. For me, it's a real priority. When you talk to hospitals, they can't find providers. And it really adds to the whole atmosphere of mental health kind of being put in on the back burner constantly in terms of how it's treated all over.

And I heard a really great story on the radio about how the State of Oregon has an incentive program where it doesn't -- you

know, in other words, I heard your comments before about workforce development and was encouraged, but I think we need to put a little muscle into it. And what Oregon does is it has an incentive program where it will pay for your education if you are committed to doing certain work in the mental health field for a certain period of time for a municipality or another governmental entity.

And I think it makes a lot of sense to encourage people to go into fields where we need them to go. And we hear all the time from professionals in the field who say, Why is this the only area where it's better to be on Medicaid than have commercial insurance? And why is this the only area where you can't find a mental health provider?

And I think, you know, wanting to expose students is nice, and we should certainly do that. But I think we're going to have to put a little money where our mouth is here and I think that helping develop some type of incentive program might be a way to go. At least studying what another state has

I think is a thing that we should do.

And like Assemblywoman Jaffee, I certainly stand ready to help in any way I can, because I think it's a huge void that I'd love to help fill.

COMMISSIONER SULLIVAN: Yes, I absolutely agree.

And I also think, on the commercial side, there is an issue of payment too. So I think people are not that interested sometimes in going into a field where sometimes the commercial rates and the payment are not what might really entice people to do this kind of work.

Just as example, in our clinic system Medicaid pays better than commercial payers in our clinic system. So there has been this disparity in mental health, not just in terms of parity for service, but parity for payment for decades. Centuries, perhaps. And I think that has to be looked at. Because it's enticing people to come into a field. We want to get them excited and do the work, but we also have to, especially sometimes on the

commercial side, think about payment that is kind of on par with what you would get for other specialties.

SENATOR KAMINSKY: Sure. And whether it's the financial issues or insurance issues or other issues, I would like to suggest that you think about coming up with a task force on how to come up with ideas on this. I know that we would certainly like to be a part of it. I'm sure it would be a good bipartisan way to start thinking about this. Because I think having a commission put forth some serious recommendations is necessary soon, and I hope I can work with you on that.

COMMISSIONER SULLIVAN: Mm-hmm. Thank you.

SENATOR KAMINSKY: Thank you.

CHAIRWOMAN YOUNG: Thank you, Senator.

CHAIRMAN FARRELL: Assemblyman McDonald.

ASSEMBLYMAN McDONALD: Commissioner, good to see you.

Thank you, Mr. Chairman.

I guess where I want to go with this

question -- I think it's budget related, to a degree. Obviously there's a lot of facilities, a lot of psychiatrists that are employed in many of the programs that you run. And at the same token, when I listen to families, when I listen to patients, there seems to be a challenge in regards to patients being able to access a psychiatrist -- particularly in the Medicaid population, but I think it could be across most disciplines or most insurance options.

So I guess my question, are you having a hard time attracting psychiatrists to practice in the facilities that the agency runs?

COMMISSIONER SULLIVAN: You know, across the country, actually, there is difficulty in recruiting and training psychiatrists. This has probably gotten worse in the last 10 years than it was that I recall, going back, partly I think because there has been some increased awareness of the need for psychiatrists, but also -- so the shortage has gotten worse.

In our hospitals and in our clinics, we have had difficulty sometimes recruiting and retaining psychiatrists. One thing which we are very happy about, and we think will begin to bear fruit, is that we now have a loan repayment program for psychiatrists that if they stay with us for five years, they will get a significant amount of dollars towards their loans from medical school, which are quite high.

So we had just started that last year, and we're beginning to get some bites from psychiatrists interested in working with us, to join us. I think that those are the kinds of incentives that can sometimes work to help get psychiatrists into the system.

That, and also we are working very hard on just trying to make sure that psychiatrists understand what the public sector is. It's not something that they often have experience with when they're training, so it's not their first thought about a job. So we're doing that. But also, I think, the loan repayment plan, which we've

put in the budget, I think will be very helpful.

ASSEMBLYMAN McDONALD: You know, one of the concerns I have is -- and I practice healthcare on a daily basis still. I see a lot of pediatricians, I see some primary care practitioners really probably practicing at the uppermost limit, if not maybe over what their experience has been.

And are there any programs or protocols to help those providers get that additional support? Because I can tell you candidly, some of these medications are not to be prescribed indiscriminately, they are very precise, they're very particular, they need a lot of monitoring and following up. And I'm just -- I'm concerned, primarily, for those primary care practitioners.

And listen, this is not a rant against psychiatrists. It's a thankless job. They do a wonderful job. But it takes time, a lot of time. And what are we doing to support our community providers that are out there?

COMMISSIONER SULLIVAN: You know, one

of the biggest shortages is child psychiatrists.

And something that we have had now for probably about three years, and we're expanding, is something called Project Teach. And Project Teach is open, free -- we pay for it. It's any pediatrician across the state can call for a consultation with a psychiatrist.

The psychiatrist hubs -- and we're using telepsychiatry for this -- the psychiatrist hubs are located at usually multiple universities across the state. All the pediatrician has to do is say they want to be involved. We offer a little training, but just as much training as they want to have. We'll train them a lot or a little.

But they can call and get a consultation with that psychiatrist and talk about, you know, the child that they're seeing and what the recommendations are.

It's been great. We have about 3500 pediatricians now; we're planning on doubling that. And we have been serving -- oh, over

10,000 families is our goal, to go up, to keep increasing.

It was a model actually in Massachusetts that we kind of stole but has been very successful in spreading the expertise of child psychiatrists especially.

A similar model is something we're thinking of to help primary care adult practices too. We haven't put that in place yet, but we're thinking about that. And we've been talking with some DSRIPs about maybe considering that. Because again, it's a very successful model in terms of providing the expertise and spreading across a wide group of practitioners.

ASSEMBLYMAN McDONALD: One final question; I know my time is short.

You know, another key component of the overall provision of mental health services is psychologists. And myself, I've been advocating looking at allowing psychologists who have received additional high-level training to have prescriptive authority on a close formulary of medications. My intent

being there's a lot of unmet need. There's also a greater recognition that there are mental health concerns that are not being treated. And we're at least getting over that stigma, thanks to a lot of the work that your agency has done, and many others.

Does the agency have a position on giving prescriptive authority to certificated psychologists for a limited scope?

COMMISSIONER SULLIVAN: No, we don't have a position on that at this time.

ASSEMBLYMAN McDONALD: Okay. Thank you.

CHAIRWOMAN YOUNG: Thank you.

Senator Carlucci.

SENATOR CARLUCCI: Thank you, Chair.

And thank you, Commissioner, for being with us here today and answering our questions.

As you know, New York State has had a strong commitment towards research and finding ways to improve the quality of life of people living with mental illness. Could you give us a brief status on the state of

research with OMH, and particularly how that relates with the agency in general, but also particularly to the Nathan Kline Institute?

COMMISSIONER SULLIVAN: Yeah, we have actually two institutes. One is the Psychiatric Institute at Columbia, in the city, and then the Nathan Kline Institute in Rockland.

And I think it's a -- I'm extremely proud of this, and I think New York State should be. We are one of the states that has continued these institutes and supports these institutes so that they can do the important work of behavioral health research.

Nathan Kline, while not quite as large as Columbia, has gotten some of the most highest-rated grants and is in a position to right now be doing tremendous work relative to geriatrics, to cultural competency. They're also doing some work on -- working with communities about setting up the appropriate services in communities.

So they do basic community work, but then they also do some laboratory work to

look at things like what are the basic causes of things like depression and schizophrenia. Similarly at Columbia, which is one of the highest-grant-funded institutions in the nation for mental health.

And so between both our Psychiatric Institute and Nathan Kline, I think we provide more in terms of psychiatric research than any other -- than large groups, including even some of the big universities you hear of across the country.

So we're very proud of it, and it's a mixture of basic science, applied work. One of the things our research institutes do is a Center for Practice Innovations, and they have come up with a whole host of curricula which we spread out to best practices to all our clinics and across the state, best practice innovations.

So really our institutes are terrific, and I think that we have, thanks to the Governor, have been able to continue to support those efforts.

SENATOR CARLUCCI: So we would agree

that money invested in research, we see that proliferate as other grants are added to that. Is there any move in this budget to increase investment to our institutes?

COMMISSIONER SULLIVAN: There's nothing in this budget that increases. But there's nothing in this budget that decreases either. So I think that the commitment is strong.

And you're absolutely right, for every dollar that we invest, there's about anywhere from $5 to $6 in grants that is built upon that dollar that we invest. And our institutions have been great in doing that.

SENATOR CARLUCCI: So if you were to invest -- increase aid to our institutes and to research in general, where would you prioritize?

COMMISSIONER SULLIVAN: That's a difficult question, because there's so many needs. I think that there's a lot of work going on now in imaging, there's a lot of work going on in cultural competency, there's a lot of work going in community-based

services, and in even some genetics, on the genome, looking at a certain markers.

So it's very wide. And I would have to actually pull together my research people and say what's your -- you know, what do you think is the most important.

SENATOR CARLUCCI: Thank you, Commissioner.

CHAIRWOMAN YOUNG: Thank you.

CHAIRMAN FARRELL: Assemblywoman Gunther.

ASSEMBLYWOMAN GUNTHER: I'd like to talk about the COLA and the lack thereof.

So it's been a decade since the state has committed to a COLA in the budget outside the 0.2 percent last year. And, you know, when we talk about adequate care and we talk about a living wage, I just -- this was also, they generated -- it was generated in the Legislature.

So what are your plans to increase the salary for people working in non-for-profits in the OMH community?

COMMISSIONER SULLIVAN: Well, first, I

think -- I just have to say that I do think that the Governor's commitment to the minimum wage is extraordinary, and millions of dollars are being invested in that. Some of those dollars will be coming to mental health, I think it's about $3.5 million, to support the minimum wage.

At this point in time, there is nothing in the budget for the not-for-profits --

ASSEMBLYWOMAN GUNTHER: I just want to interrupt. Is that for like the non-for-profits, the minimum wage?

COMMISSIONER SULLIVAN: Yes, that will include --

ASSEMBLYWOMAN GUNTHER: When will that be coming?

COMMISSIONER SULLIVAN: There's about $3 million in the budget to support the minimum wage uptick for this year, in this budget.

But your other question about more than that, there isn't anything in the budget that would address the COLA. The COLA is not

in the budget this year.

ASSEMBLYWOMAN GUNTHER: The other thing I wanted to talk about, stigma. Last year we had the tax checkoff. And how much money did we accumulate, and what are we doing with it?

COMMISSIONER SULLIVAN: There was about $75,000 that came in from the tax checkoff. And we got a group of stakeholders together to decide what to do, and I think we'll be sending out very shortly an RFP for a little -- what the stakeholders decided was to do 15 small grants of $5,000 each that would go to individuals to work on stigma, whether it was education or working with families, working with institutions. But to work on stigma.

So small grants. We're looking for innovative proposals. And if some of those small grants look like they are successful, then perhaps next year, when perhaps we'll have more money that will come in -- we would love to get more -- those could be expanded. But that's the plan for the dollars at this

point. And that should be starting very, very soon.

ASSEMBLYWOMAN GUNTHER: I misspoke a little bit when I said minimum wage. There's a compression issue. And there's also -- to pay a DSP what we consider minimum wage, to keep those folks in this profession -- what I'm talking about is additional, beyond and above that. Because this is truly not a minimum wage job.

And what are we really doing to keep these professionals in the profession? I think that's what's really important here. I misspoke. Because I know that, you know, we're doing it in increments in upstate New York. But we're talking about a group of non-for-profits that really have been starved over the years.

And keeping somebody in the DSP profession, and then you add in the Justice Center with it, it's really, really difficult. It really, really is, you know, in OPWDD and in OMH. But right now, you know, I think that, you know, minimum wage is

just not going to make it. You know, in order for people to take care of people in facilities and so forth, and in the community, you know, we need to invest more money in that.

COMMISSIONER SULLIVAN: You know, there isn't anything in the budget in this year that would address that, an addition to the minimum wage. I think that the Legislature -- this is an important issue, and I think that the Executive will be, as it always does, working with the Legislature on the issues that they feel are important over the course of the budget negotiations.

ASSEMBLYWOMAN GUNTHER: Can we use any of the DSRIP money for this?

COMMISSIONER SULLIVAN: Oh, that's something that I think you would have to talk to the Department of Health about. The DSRIP dollars are really within the Department of Health.

ASSEMBLYWOMAN GUNTHER: Have you suggested it, just because it's so important to this field?

COMMISSIONER SULLIVAN: I have not, no.

ASSEMBLYWOMAN GUNTHER: Thank you.

CHAIRWOMAN YOUNG: Thank you.

Senator Gallivan.

SENATOR GALLIVAN: Thank you.

Good afternoon, Commissioner.

I'd like to talk about, as you can imagine, the Western New York Children's Psychiatric Center. I apologize that I wasn't here for all of your testimony, but I was at a hearing on the issue of raising the age of criminal responsibility in New York State.

Among the proposals, the Governor's proposal, is -- the Governor's proposal deals with a couple of different things: Programming, certainly the courts, Family Court jurisdiction. It also deals with housing. And one of the biggest things that the Governor has called for and that people have testified to is to remove 16- and 17-year-olds from adult prisons. Not just separating them by sight and sound in the

same facility or the same campus, but physically getting them into a different building, into a different structure, and away from the adults.

And as you know, I of course disagree with the decision to close the facility and merge it with the Buffalo Psychiatric Center. But for the life of me, I just can't understand on one hand how the Governor can be calling to get convicted criminals out of prisons at 16 and 17 years old and give these juveniles their own facility, and at the same time close the West Seneca Children's Psychiatric Center, where we have kids that are among the most troubled in the state, we have a facility -- the professionals there are among the best in the state, if not the country. By the various metrics where you measure their success, they perform extremely well, if not among the best in the state -- and we're putting them back in an institution that they were removed from 40 years ago because the experts at the time said that they should be separated.

I am just -- I am completely troubled by it. I still have yet to hear any clinical reason for it to take place. And nobody has been able to present that these kids would be better off in that adult setting.

We have conducted a number of hearings, as you know. And of course I attended the forums that you put on to hear input from people. Many stood up and made a plea or an appeal to you to keep it open.

But I've heard from children and former patients, families, parents, the professionals that work there, various mental health professionals and organizations, members of the community, and every single member of the Western New York legislative delegation who is opposed to this. And I just don't understand how this can be done when there's so many opposed and there is no clinical reason for this.

COMMISSIONER SULLIVAN: I appreciate the --

SENATOR GALLIVAN: That is not a question. I understand --

COMMISSIONER SULLIVAN: I know, I know. And I certainly --

SENATOR GALLIVAN: But please comment.

COMMISSIONER SULLIVAN: -- I appreciate it.

The goal here is really to enable a system of care, to enable Mental Health to provide the services that a community needs.

In terms of the quality of care, I do not believe there will be any difference in the quality of care -- I know we disagree on this -- in relocating from West Seneca to Buffalo. I think that the plans that we have, the clinical staff, the way it is designed, which is extremely youth-friendly, will provide the same great outcomes that West Seneca has always had.

Why do it then? We'll do it because by doing it, we are enabling over $3 million, $3.5 million in investment in community services in that area which are desperately needed.

I think when you look at healthcare, this is something that is happening in

healthcare across the country. People are trying to design systems of care that can make those precious healthcare dollars reach as many people as possible while still providing quality care. That's why we're doing it. I know we disagree, but that's why we're doing it.

SENATOR GALLIVAN: I understand.

What if we are able to find sufficient funding to cover that?

COMMISSIONER SULLIVAN: I think the issue here is spending the dollars well. I mean, I always like extra funding for things, I'm not saying not. But it doesn't make sense to me to not be using dollars in a way that can provide the best service to the widest group of patients and to really serve the community.

SENATOR GALLIVAN: I have to respect the rules of timeliness here, so I'm at the end of my time.

I do want to say, though, that I do appreciate that you've always been positive in getting back to our office and dealing

with any of the questions that come up, even though we continue to -- or I continue to disagree about this issue and we'll still continue to work through the budget process to reverse the decision.

Thank you.

COMMISSIONER SULLIVAN: Thank you. Thank you.

CHAIRWOMAN YOUNG: Thank you.

Chairman?

CHAIRMAN FARRELL: Assemblyman Santabarbara, to close.

ASSEMBLYMAN SANTABARBARA: Okay, thank you.

I just want to talk a little bit about stigma. We all know there's a tremendous delay, sometimes as much 10 years, between the onset of symptoms and people actually seeking treatment. And we hear that it's one of the biggest factors in this delay.

Two years ago we passed a tax checkoff box for mental health stigma. And are there plans now to utilize this resource to combat stigma? And what other actions is OMH taking

to encourage people to actually get the treatment?

COMMISSIONER SULLIVAN: The tax checkoff was about $75,000. We're hopeful this year there will be more. And the plan is to send out 15 small $5,000 grants to an RFP for either local providers, some of our peer groups, some of our individuals to come with a proposal so that we can seed an anti-stigma approach. And then, based on some success with that, we may be able to use money that would come with the anti-stigma checkoff this year to enhance those programs.

So we're really very excited about this. We decided to do this with a group of stakeholders which included some providers, included clients and recipients, included families, as to how best to use the $75,000.

On the issue of stigma, you're absolutely right, it's a huge issue. I think, my experience -- I've been in this field a long time -- it's getting better, but it's nowhere at all where it needs to be. People are still afraid of seeking services.

One of the key things that we are doing, though, with individuals -- you're absolutely right about this lag in time of getting treatment. And that lag is particularly onerous for individuals who are diagnosed with schizophrenia. So we have something called the first-episode psychosis program in the state, which we are growing across the state. So that when someone has that very first episode -- because usually they have the first episode and then they get lost for exactly the time period you're talking about -- to engage the family and the client to keep them in school, to keep them working, not to get lost to the system and lose their community supports, which is what has unfortunately happened.

So right now we have that in 13 sites across the state. We're going to continue to expand it, hopefully to be able to reach everyone who has that first experience of a psychotic episode, so that they can get the kind of services they need to get into treatment early and continue their lives and

not get separated, which is a very critical issue.

ASSEMBLYMAN SANTABARBARA: Thank you.

Just moving back to the workforce, the state workforce, according to the stats that I'm looking at here, 35 percent of OMH employees are working overtime. So just curious how you're addressing this while also eliminating 353 FTEs.

COMMISSIONER SULLIVAN: Basically, we're lowering 353, but it would have been 453. So 100 are being retained to basically try to deal with the overtime issue.

Overtime is complicated. One of the issues is an increasingly acute number of patients that are coming into our hospitals, a lot of one-to-one observations, as we call it. We need to redesign what we do in terms of clinical care so that that may not be as necessary, although you always have to order it if you need it.

The other is hiring time. There's a number of Lean projects that the state has taken on to get people on-boarded quicker.

Overtime becomes a real issue if you're not really quickly replacing one individual after the other. And we're also working closely with Civil Service about having exams in perhaps a more timely manner so that we can begin to fill positions quicker.

So -- and the other is working with some staff -- I think about 10 percent of staff are out sometimes on leave because of injuries in the workplace. It's all very high in healthcare, higher in psychiatric care. And we're doing a lot of work with teamwork and other things to reduce that so there will be less happening so people won't be out on leave.

So there's a number of initiatives, and 100 coming back.

ASSEMBLYMAN SANTABARBARA: And just sticking to that topic, so you see a need -- is there a need to increase salaries? And what are the stats on the retention, keeping employees?

COMMISSIONER SULLIVAN: I think it's -- salaries are very volatile in the

mental health field right now, whether it's for nurse practitioners or psychiatrists or nurses. Whenever you have staff shortages, salaries go up, kind of supply and demand.

So we are looking into multiple pieces of the puzzle as to where we may need to look at salary increases.

CHAIRMAN FARRELL: Thank you.

ASSEMBLYMAN SANTABARBARA: Okay.

CHAIRWOMAN YOUNG: Thank you, Commissioner. That concludes our questioning today. So we truly appreciate your participation, and I'm sure we'll be talking with you very shortly. So thank you so much.

COMMISSIONER SULLIVAN: Thank you very much.

CHAIRMAN FARRELL: Thank you.

CHAIRWOMAN YOUNG: Our next speaker is Helene DeSanto, acting executive deputy commissioner of the New York State Office for People with Developmental Disabilities.

Thank you. Welcome. We look forward to hearing what you have to say.

ACTING EXEC. DEP. CMR. DeSANTO:

Thank you. Good afternoon, Senator Young, Senator Savino, Assemblyman Farrell, Senator Ortt, Assemblywoman Gunther, and other distinguished members of the Legislature. I am Helene DeSanto, acting executive deputy commissioner for the New York State Office for People with Developmental Disabilities, OPWDD.

Thank you for the opportunity to provide testimony about Governor Cuomo's 2017-2018 Executive Budget proposal and how it will benefit the more than 136,000 New Yorkers with intellectual and developmental disabilities who are eligible for OPWDD services.

Under the Governor's leadership, OPWDD continues to make significant strides in the transformation to a more integrated, person-centered system of services and supports for the people we serve. This year, the Executive Budget proposes $4.3 billion in state funding -- $7.3 billion including federal funds -- to support integrated, community-based services and OPWDD's

oversight of state and not-for-profit providers.

OPWDD's ongoing systemwide transformation is informed by an unprecedented level of engagement over the past two years with individuals, families, our nonprofit provider partners, and you, our partners in the Legislature. This feedback has led to significant new investments in the 2017-2018 Executive Budget.

This year's budget proposes significant new investments in integrated OPWDD services, including $120 million in all-shares funding to expand services for new and currently eligible individuals; $27 million in all-shares funding to support provider agencies' compliance with new minimum wage standards, $24 million in new funding to support people's transition from developmental centers to appropriate community-based settings, $15 million in capital funding to expand affordable housing opportunities for OPWDD-eligible people, and a $21 million investment in expansion of

OPWDD's successful START program, our crisis response, intervention and treatment program.

In addition, as part of OPWDD's ongoing transition to managed care, the budget provides for OPWDD to access Department of Health resources to cover the administrative costs associated with managed care. OPWDD is committed to reinvesting any savings that are realized from its transition to managed care back into services for people with developmental disabilities.

New York funds and operates the nation's largest residential support system for individuals with intellectual and developmental disabilities -- a $5.1 billion annual investment. More than 37,000 New Yorkers currently live in OPWDD-certified housing, such as group homes, and another 4,200 are eligible for rental vouchers that assist them to live independently within their communities.

Still, the need to expand residential opportunities for the people we serve is a major focus for OPWDD. Many families remain

concerned that there won't be an available housing opportunity when their loved one needs one. With the Governor's support, OPWDD has developed a multiyear housing strategy designed to meet the identified demand.

In the next three years, OPWDD anticipates that approximately 4,900 individuals currently living at home may require a certified residential opportunity and another 1,400 will seek more independent living arrangements than rental subsidies and other uncertified options can provide. OPWDD will meet this demand using a mixture of existing and newly developed opportunities which will be accessed based on a person-centered process.

OPWDD will also participate in the Governor's $20 billion affordable and supportive housing plan and, as mentioned previously, access $15 million in capital funds to help develop independent housing opportunities in communities throughout the state.

Before taking your questions, I would like to acknowledge the concerns related to the people who are the foundation of our service system for New Yorkers with intellectual and developmental disabilities, our direct support professionals. We are engaged in regular and ongoing dialogue with our provider partners on solutions to address their workforce concerns.

While the budget includes $27 million in state and federal funding to support increases in the minimum wage for direct support professionals, we recognize the need to continue our focus on efforts that will address recruitment and retention of a highly qualified and stable direct support workforce.

Thank you for your continuing support and advocacy. We look forward to working with you, our partners in the Legislature, and all of our stakeholders to achieve real and lasting systemwide transformation on behalf of our friends, neighbors and loved ones with intellectual and developmental

disabilities.

I welcome your questions.

CHAIRWOMAN YOUNG: Thank you, Ms. DeSanto. And I do have a few questions.

My background is -- I worked at an agency for people with disabilities for many years before I ran for state office, and this whole issue of managed care has me concerned because it's so undefined right now. And you only referenced it in passing in your testimony. And we've tried managed care many, many times over the past many years in the state, and it's never worked.

So the Executive proposes to transition all the developmental disabilities population over to managed care within the next five years, and it would start with the development of regional care coordination organizations which would initiate enhanced coordination of care, according to what we've heard so far. And after you develop these organizations, the Governor would transition to a fully capitated rate structure for reimbursement and for voluntary enrollment, I

believe, which would start in 2019.

But those were the only details that we have on the entire plan, so can you provide more specifics as to how you would impose managed care for habilitative services that people with developmental disabilities require? Because as you know, there are many people out there that are vulnerable citizens. They depend on getting the services that they currently have. And so how would you handle this?

ACTING EXEC. DEP. CMR. DeSANTO: Thank you. So we are looking at a variety of strategies and working with our provider community to really ensure that we put together a good plan to transform the system and to move to managed care for the population that we support. And as you referenced, the plan would begin with voluntary enrollments in 2019. So we have a couple of years where we really are working with our provider community and moving toward a care coordination approach, which is a central aspect of a managed care system.

CHAIRWOMAN YOUNG: So it's voluntary to start. Would it become mandatory at a certain point?

ACTING EXEC. DEP. CMR. DeSANTO: At a certain point it would, over a five-year period beginning in 2019.

CHAIRWOMAN YOUNG: So it's voluntary to start for what length of time?

ACTING EXEC. DEP. CMR. DeSANTO: It is voluntary to start for -- I want to say it's two years, and then it begins to go into a mandatory approach after that.

And it would be rolled out in geographic parts of the state. Where we have greater readiness, probably downstate, we would begin earlier than moving upstate, is the thinking currently.

I think what I just want to mention is that what we really see as the benefit of moving to managed care is the flexibility that it will offer us, which is a greater degree of flexibility in our service system. It's where we've been trying to move our services in a transformational approach, and

it certainly holds the promise of some savings that might accrue that would enable us to do further investment in some needed services.

So I think that that's kind of the big-picture view of it.

We do have a small demonstration project in New York City right now that has been operating for about a year now, and so we have some ways in which we are looking at how best to make the transition and sort of learning from some experience there.

CHAIRWOMAN YOUNG: Okay. Thank you. And I'm sure we'll be talking about this as time goes on.

You referenced the direct care workers, and we've been very concerned about the minimum wage increase and the fact that there's now a gap with, for example, fast food workers and direct care workers. And you reference a little bit about the recruitment issues. But working, especially with people with severe disabilities, is a very, very, very difficult job. And if you

could choose between flipping burgers at McDonald's or having to change diapers or maybe taking care of someone who may act out, may bite you, may hit you, whatever it is, most people would probably choose working at a fast food restaurant.

So it's always been difficult to recruit direct care workers. I think it's becoming impossible to be able to recruit them, and I wanted to get your thoughts about it, because the Governor includes $14.9 million in state funds, $27.4 million gross, to fund the cost of not-for-profit providers under OPWDD impacted by the scheduled increase in the minimum wage. But as I said, providers are no longer able to offer a better wage than other businesses, and providers are really concerned.

I've been hearing about this -- in fact, my office just sent me a resolution that was passed by the board of an ARC in my district, and I just got that this morning. So the Governor's created a situation where the developmental disability providers may

have a tougher time -- they are having a tougher time in recruiting staff.

And, you know, one of my concerns also has to do with the fact that quality of care can be compromised if we don't have the right staff members on board. So how are we going to address this? Because I don't see that it's really being addressed right now.

ACTING EXEC. DEP. CMR. DeSANTO: So first I want to reiterate, I think, a point that you made which acknowledges the fact that we have very strong support from the Governor, with the $27 million investment this year to make sure that our providers can meet the minimum-wage standard. And I know that that was certainly a great interest to our providers as minimum wage was rolling out.

However, we know that that's not, you know, perhaps going to solve all of the issues around recruitment and retention for this workforce. And you're correct, I mean it's a very -- you know, it's a very demanding job, and it is -- the very

foundation of the services that we provide is built upon that direct support workforce, day in and day out.

So we have been working with our providers to really look at what kinds of issues they are having with recruitment and retention. We have had a working group established to look at things such as compensation. But, in addition, things that also contribute to workforce satisfaction in our field that have to do with the training that they receive, the career ladders that are available within human services agencies, and some of the things that really, I think, are unique and distinguish the job of direct support in our field compared to maybe some of the other entry-level jobs that you were referencing.

So we're looking at a whole variety of factors. And we are, you know, certainly more than willing to work with you during this budget process to see if there are more things that really should be done.

CHAIRWOMAN YOUNG: I appreciate that

answer very much, Ms. DeSanto, but I -- you know, and it's good to look at the entire picture, but unless you can pay somebody a good wage, they're just not going to be that interested in that job. Because you know what, they have to support their families too. And I know you understand that, so thank you.

CHAIRMAN FARRELL: Finished?

Assemblywoman Gunther.

ASSEMBLYWOMAN GUNTHER: Okay, we talk a lot today about percentage changes, millions of dollars here, thousands of dollars there, service cuts, rates and bed values. We also talk in many acronyms -- dSRIP, APG, CCO. All this is really talking about people, vulnerable people who need our support to live their lives to the fullest.

We are talking about people who take care of those people, their families, friends, and direct support professionals who dedicate, and I repeat dedicate, their lives to providing critical, invaluable care.

Why was the $45 million that was

requested to address the minimum-wage issue and compression issue not included in this budget?

ACTING EXEC. DEP. CMR. DeSANTO: Well, what I would say is --

ASSEMBLYWOMAN GUNTHER: Remember, I have to say that it's hard, it's hard for me -- you know, I grew up in middle-class America. And when I look at the number $159 billion, and then I look at $45 million to support people that otherwise are going to -- they'll quit their profession.

You know, they're trying really hard. And the other side of that equation is most of them are women, and many of them are single women. Many of those are women with children that are also -- could be single -- working not one but two jobs. And then you layer on top of it the Justice Center, the Justice Center, and the intimidation that people feel.

You know, they have love for their consumers, but they need to feed their family. And so $45 million in terms of

$159 billion -- I'm not an accountant or a mathematician, but I know it's like spitting into the ocean.

ACTING EXEC. DEP. CMR. DeSANTO: So, you know, what I would reiterate again is there certainly is a good amount of dollars that are devoted to the direct support workforce in this budget, as well as a lot of other important initiatives. And I agree with you that, you know, it certainly is an area that needs consideration and focus. But within the limited availability of dollars and the big picture, I think that the budget was not, as it was constructed, did not include the dollars that you're referencing.

So at this point I think we can continue to discuss and work together as the budget process goes forward to see if there is, you know, a way to address those concerns.

ASSEMBLYWOMAN GUNTHER: You know, we have discussed it over the years. It's been every not-for-profit that I can think of has come in and discussed this issue with so many

people, have pleaded for these increases.

And I think that again, we're talking about a very vulnerable population. You know, I have -- I know one agency, a not-for-profit that talks a lot about our disabled community that's being cared for for much, much more money and out of state.

And the fact is, why aren't we looking to save money bringing those people from out of state? And we know where these agencies are, that they're paying probably 40 percent more to send them to out of -- and we do have what we need in New York State to care for these folks. But once we place somebody there, they seem to stay there forever.

And I'm saying that we could save money, and it would be better for a family to have your loved one here. But there are ways to save money.

But right now, the DSP, there are a lot of professionals, a lot of them go to a lot of classes, they really do. And tie in the fact that the Justice Center comes in and there's an allegation, and then they decide

what level of allegation it is. And what happens is there's an investigation. The performance improvement person starts the investigation, they send it up to Albany, to the Justice Center -- sometimes people are out six to nine months without any kind of resolution to the issue, and a lot of the times not guilty.

And, you know, between that and not giving these not-for-profits -- they're going to go broke. And I think that it should be a priority in the State of New York to make this happen.

ACTING EXEC. DEP. CMR. DeSANTO: Thank you.

ASSEMBLYWOMAN GUNTHER: That's it, eh? I know. Okay, thank you.

CHAIRWOMAN YOUNG: Thank you.

Senator Ortt.

SENATOR ORTT: Good afternoon. At the risk of beating a dead horse, I'm going to beat a dead horse. Is it OPWDD's contention that DSPs deserve to only make the minimum wage?

ACTING EXEC. DEP. CMR. DeSANTO: Well, I would say certainly not. We certainly are happy that we are able to bring all of the employees to minimum wage who are not currently there. I think you may know, Senator, that there is a good percentage of the direct support workforce that are already above minimum wage, which is a great thing.

But we certainly recognize the type of work that the direct support professionals do. We have had cost-of-living increases over the years because we've recognized, you know, the importance --

SENATOR ORTT: Do you know when the last one was?

ACTING EXEC. DEP. CMR. DeSANTO: Yes, it was -- actually, the last one was 2015. And there was one the year before that, 2014, both of those being 2 percent. And there was a small cost-of-living adjustment last year, which was based on the CPI, which I think you probably may --

SENATOR ORTT: 0.2.

ACTING EXEC. DEP. CMR. DeSANTO: --

recall. Yes, that's correct.

So, you know, what I would say to you is no, we would certainly never suggest that our direct support professionals don't provide a very valued service. That really, you know, we would want to do everything we can to ensure that we have adequate recruitment and certainly retention of our workforce.

SENATOR ORTT: I'm sure it's not lost upon you or the folks at OPWDD that what we're really talking about, though, here today isn't just the DSPs. We're talking about the people that they service. Because when the wages are low and you've created -- because we created a more urgent situation. This was already a problem with recruitment and retention, but now through the state's action last year, and the fact that the Governor was very eager to be out there in front for minimum-wage workers -- and it sends a priority, or it's a signal that the priority certainly is not within this group.

And I think that if you listen to the

speakers who are going to be coming after you who have been in this field for years -- much longer than I've been serving in the Senate, maybe longer than you've been in your current position -- they will tell you that the feeling within the developmental disability community amongst families, amongst workers, non-for-profits, is that quite frankly this administration simply does not prioritize this area.

And you can look at the funding. You termed "strong support," $27 million. That's certainly your description. There is not one speaker coming later this afternoon that would term that as strong support. They would look at it as no support, because they would say that the COLA has been deferred, there is no cost -- the $45 million they're looking for. And ultimately, you can't recruit these people.

What happens is you get probably a subpar, I'll just say it, a lower-quality worker. It's like any other job or any other industry. You know, someone's going to fill

the job, but they may not be as good as the people that were trying. And these are people who are working with people's children, very vulnerable people, as you know.

So I think when you hear these questions and you hear the concerns, it's not just because -- it's not just the workers, although we want them to have a livable wage, but the good ones, you know, the reality is they're going to go -- they're going to find that wage somewhere. They'll leave this field, they'll go to Burger King, they'll go to Wendy's, they'll go somewhere. They'll go work for a school district.

But the person who can't go anywhere is the individual who they're servicing. See, they're stuck. So they need that person to earn a livable wage, so they can continue to provide the service and the care they need.

So you're certainly free to comment, but I think that that's a very important point.

ACTING EXEC. DEP. CMR. DeSANTO: Yeah, I mean, certainly we realize that ultimately it is all about being able to support the people that are reliant on our services. And we know that it's a field where the very health and safety of individuals, day in and day out, rests with our direct support professionals. So there's no question about the valuable role that that workforce plays.

And I have to say to you, Senator, that we do talk with providers, parents, and many stakeholders that carry the very message that you are speaking about. So we are acutely aware of it. We certainly also have a lot of service needs that are very well resourced in this budget for which we're very grateful, and we get the support of the Legislature again and again, year after year, for a lot of the service dollars that we do need.

So I think we have to continue to work together on this issue and really look to see what can be done that might be able to address the kinds of concerns that you're

referencing.

SENATOR ORTT: I have two more questions -- three more, I guess.

According to your report by Comptroller DiNapoli, OPWDD lost 4,341 state employees, or 17.5 percent of its workforce, between 2007 and 2015. How has this reduction affected overtime within the office?

ACTING EXEC. DEP. CMR. DeSANTO: Okay. So in the time period that you reference, there was a great deal of progress made in reducing our institutional population, and a lot of the workforce reduction that you reference had to do with being consistent with the loss of services that were provided on our campuses and the move, of course, to more community-based settings, which was a goal certainly of OPWDD and continues to be.

During the last year, I'm very happy to say, we have seen a reduction in our overtime hours of 13 percent. So what you will see in the coming reports from the Comptroller will show that we've had a lot of

success in overtime reduction just in the last year. And we've achieved that by focusing on a number of areas.

One of them is getting employees in the door, as we have ongoing vacancies, more quickly, being more efficient in the hiring process for our state direct support workforce. We've also worked to reduce times that people are on leave, because, you know, people on leave obviously results in overtime and takes away from days on the job.

And so with those strategies we've been quite successful in seeing overtime reduction. And, you know, we do monitor it very carefully, pay period by pay period, and we look to see also that people are not working extreme schedules. So we also have seen a reduction, and a good reduction, in the amount of overtime hours that any one particular employee might be working within a pay period. And that's also an area where we've seen some success.

So we'd love to continue to have conversations with you throughout the year to

kind of show you the tracking that we're doing and the success that we're having.

SENATOR ORTT: The reason I'm asking is because the proposed budget calls for elimination of an additional 253 FTEs. I mean, one would have to believe that that's going to increase overtime costs on current employees. And I guess my question is, why eliminate these positions instead of maybe utilizing them to reduce overtime instead?

ACTING EXEC. DEP. CMR. DeSANTO: Yes, well, the positions that you reference are directly related to a decreased census in certain locations in the state.

And whenever we have an institution that closes or other downsizing, I'm very pleased to say that we work with the unions -- and we have not had certainly any layoffs, as I'm sure you know -- but we also work very hard to keep people in jobs right in the geographic location where they currently work. So, for instance, for people who were working in a location where an institution may close, they would go into

work in locations in the community of that same facility.

But the reductions that you reference are related to workload, if you want to say reductions in services that are state-operated in those areas.

SENATOR ORTT: The last and -- I have to be respectful of our time as well -- my last question at the current time is regarding respite, which I have no doubt you're familiar with, and respite rates.

So there is a gap, if you talk to folks at the ground level, between respite that's authorized and respite that's utilized. Because the rates in many cases simply do not -- you know, providers are losing money on respite and, ergo, they're not offering it.

For many families, respite is a lifeline without in-home supports or without placement options. And so I hear from family member after family member, We need more respite, we need actual respite that's offered in the area.

We need to look at respite utilization, which -- there is that gap. Can you explain the gap or speak to the gap and tell me what OPWDD is looking at to offer more respite? Because I really think this would do a huge -- it would perform a huge function to reduce that tension on the placement side if you had respite, which would be the community support.

ACTING EXEC. DEP. CMR. DeSANTO: Yes, and that's absolutely correct, Senator. You may recall that when we did our report a year ago, now, in February on the residential request list, that was one of the very significant findings.

We had families who were on that request list -- that you all I think are aware of -- tell us that if they had available to them more respite opportunities, they would not necessarily be looking to have their family member move, at least not yet. And we have done a lot of work in the last year, really, looking at respite -- the fees that providers are paid, and doing some work

in that area to better define some of the respite services and to work on the different respite payments.

And that's a work in progress. We actually have been working with all of our providers to gather information. We have another webinar with our respite providers later this week. At that, we'll talk with them some more about the different ways that we're working to fund the amounts of payment that providers receive, particularly for individuals who have high needs.

We're trying to recognize within our rates a better approach to meeting high needs, because as you might imagine, a family with a family member at home who has these high needs, they're particularly needy in the area of having respite. We are looking at ways in which we can ensure that people receive the respite services that they're authorized for and receive them in a more efficient and timely manner. So we're doing a number of things in that area as well.

SENATOR ORTT: Thank you.

ACTING EXEC. DEP. CMR. DeSANTO: You're welcome.

CHAIRWOMAN YOUNG: Thank you.

CHAIRMAN FARRELL: Thank you.

Assemblyman Crouch.

ASSEMBLYMAN CROUCH: Thank you.

What's the status of the workshops at this point in time? The Governor proposed eliminating the sheltered workshops back in, I think, 2013, and the doors were shut as far as any new intake. What's the status at this time?

ACTING EXEC. DEP. CMR. DeSANTO: So the status of the workshops is that we have been working over the past year and a half with providers to go more toward an integrated business model, and providers are working on plans. We have actually received, from most of our 80 workshop providers, plans for them to go forward with the transitions that we discussed.

And you may know that providers do have a period of years to make that transition, so it is until the year 2020 that

providers would have to make those transitions happen.

We have done an awful lot of work with our workshop providers. We do get good feedback that our providers of workshop services are, you know, moving along toward the types of services that we had been planning with them, and actually we get some very good family, individuals, stakeholder feedback as well at this point.

So I think we're well along the way to the point where we were originally discussing with our goal for the workshop programs.

ASSEMBLYMAN CROUCH: So will they ultimately close, then? Or this business plan will salvage the workshops?

ACTING EXEC. DEP. CMR. DeSANTO: It will ultimately transition the types of services that are offered there to make them more integrated, and we also have come up with some different services within our system that will ensure that people who are there in the workshop will be able to continue to receive the types of day-to-day

supports that they were interested in.

So I think we did a lot of work, given all the input that we received from members of the Legislature and our stakeholders, to really get to a place that I think people are satisfied with in terms of the transition.

ASSEMBLYMAN CROUCH: Is there intake now, then? Or is the intake still stopped until you've come up with this other plan?

ACTING EXEC. DEP. CMR. DeSANTO: At the point at which the plans are approved, the intake continues to go forward. So I think we're at a point where we're able to begin to receive people again into those types of services that they're looking for.

ASSEMBLYMAN CROUCH: So you are taking new people in?

ACTING EXEC. DEP. CMR. DeSANTO: We are in the process of reviewing the plans, and when we have an approved plan, that is the point at which we would be taking people into the services.

We also have, though, a number of services that have been introduced over this

past year and a half, and people have continually been received into those services. So there's been no one who has not had a service available to them.

ASSEMBLYMAN CROUCH: What about the people from 2013 to 2017 that would have liked to have gotten into the workshops for services, what's happening with them? Are they currently just sitting at home, or are they able to receive some different type of service?

ACTING EXEC. DEP. CMR. DeSANTO: They are receiving services, so that we had always had available a variety of services that people could be offered.

We now have a community pre-vocational service that might be available to some of them, if that would be their choice for what they would want to go into.

We have a new service called Pathway to Employment that enables people to explore the types of jobs that they may be interested in, and we have a number of people who went into the Pathway program.

And of course we have our supported work program, so some people may have chosen to go right into the supported work area.

ASSEMBLYMAN CROUCH: What if the individual does not want to leave the workshop? If they're perfectly happy with their job at the workshop, are they able to stay?

ACTING EXEC. DEP. CMR. DeSANTO: Yeah, sure. So the whole goal of the workshop transition was to create opportunities within that same type of setting, but to get that setting to be a more integrated type of employment than what it had traditionally been. So we had always been committed to not telling individuals who were currently working there that there was a point where they would have to leave that setting, and that has not happened.

CHAIRWOMAN YOUNG: Thank you.

ASSEMBLYMAN CROUCH: Is there money to -- I'm just -- I have one quick question. Is there money allotted to help these transitions to the workshops?

ACTING EXEC. DEP. CMR. DeSANTO: There is certainly funding that is connected to the various types of services that we're speaking about, and we have worked with our providers on their transition plans and the transition processes.

We do have a good amount of federal dollars that are referred to as Balancing Incentive Program dollars, or BIP is the acronym there, and those dollars were provided for the very reason of transformation and transforming services into more integrated services. So a number of providers received dollars that related to this very issue of workshop transition and to assist them in that regard. So there were investments made there.

ASSEMBLYMAN CROUCH: Thank you.

CHAIRWOMAN YOUNG: Thank you.

Senator Krueger.

SENATOR KRUEGER: Thank you.

Good afternoon. Just to reiterate what already has been said just one more time, you can't stop the COLA from going

forward at the same time as we've increased minimum wage and the pressure on providers to actually get people to work for them and stay in these very difficult jobs. It's a lose-lose proposition. So you've heard it a million times here today, so just please urge -- go back to the Governor and say this is just not an option that can be considered.

You talk about, in your testimony, when you add up 4,900 individuals currently living at home may require a certified residential opportunity and an additional 1,400 will seek more independent living arrangements than rental subsidies and other uncertified options can provide -- so that's 6,300 people, I think, that you're saying are in need of residential facilities.

So I represent Manhattan, parts of Manhattan. I get visits and calls from people all the time begging for help to get residential placements -- not next year, but now. People who have been waitlisted, people in their 50s, 60s, 70s, 80s caring for OPWDD adult children who can't do it anymore and

live in hopes of finding a secure, safe place for their adult children to move to.

Of these 6,300 that you're defining, when are we getting them into the correct placements? And, two, give me an estimate of how many of those are in New York City, because I feel like we have a desperately high waitlist.

ACTING EXEC. DEP. CMR. DeSANTO: Sure. So in developing the multiyear strategy, we looked at various points of information. You probably know we have that large residential request list which is statewide and is just that, it's a list where at some point people have requested or said that they may have an interest in residential support.

But then what we also have in our regional offices is a process, a very dynamic process whereby we receive information from families and/or their case managers that are probably the people that you described, who are saying "I am ready now, and I need services now."

So each of our regional offices,

including our regional office in New York City, maintains that list and they work on an ongoing basis with providers in their area as vacancies in our system come up, or to develop new residential opportunities that may need to be created. And, you know, you might realize that in such a large system as we have, which is 37,000 individuals, there is a good amount of turnover on an ongoing basis within a system so large as ours.

So it's a two-pronged process of looking at how to make sure that we make the best use of that large system that we have invested in. And it's a very large system in New York City. You're probably aware of many of our providers there who operate many different types of residential supports, as well as, as I said, looking at the creation of new opportunities.

Now, I know that many families are concerned, that they feel that there's a need for a greater number of new opportunities to be created. And so part of this multiyear strategy actually does increase the number of

new opportunities that are created for family members who are caring for a loved one at home.

This past year, we devoted $10 million on a dedicated basis to individuals who have family members that they're caring for at home, and we had a stakeholder process where people recommended to us how to invest those dollars around the state. And we're coming to a conclusion of that process, which should see approximately 170 new opportunities of various types created around the state in various areas.

I mean, I could certainly arrange to sit down with you and more specifically look at our New York City information that we have. And we'd love to hear what information you have, because we always want to make sure that we are as accurate as we can be and that we're being responsive in all parts of the state.

SENATOR KRUEGER: So just globally, you have 37,000 residential slots in OPWDD. You have stated there's approximately 6,300

units needed by people on lists. And you talk about turnover. How many people turn over in your system per year?

ACTING EXEC. DEP. CMR. DeSANTO: About -- I'm trying to do the math quickly in my head. It's about 1,800, I believe, that would turn over within that existing system of 37,000.

SENATOR KRUEGER: So current demand is, at minimum, three times what your turnover is.

ACTING EXEC. DEP. CMR. DeSANTO: Well, over that three-year period. So the 6,300 is anticipated over a three-year period to be --

SENATOR KRUEGER: Over a three-year period.

ACTING EXEC. DEP. CMR. DeSANTO: Yes. That's correct.

And the other thing I just want to point out is that we also have other types of housing supports now that we did not have for many years. For many years it was a one-size-fits-all system where we would create your classic group home, for lack of a

better way perhaps to say it, but not a lot of more integrated or individualized opportunities such as apartment types of settings, vouchers that help people who want to live more independently to do that. And now we have those types of options that people are accessing to a much greater degree.

When we did that outreach a couple of years ago to the people on our list, we actually found that many of them were telling us they wanted to know about these new and different types of opportunities. They weren't just necessarily saying, you know, that the group home was the only option that they would consider. So there are people on that list, you know, who are capable and really desirous of having different types of opportunities that we're now able to also develop that were not there before.

SENATOR KRUEGER: Not to play the devil's advocate totally, but I assume those people actually, then, can get those services so they wouldn't be on this list.

ACTING EXEC. DEP. CMR. DeSANTO: Well, actually, people with all levels of need are on our list. But certainly some people may, as you experience or say that people tell you, wait longer than others. People who need a highly specialized service, obviously that sometimes could take longer to match people to.

SENATOR KRUEGER: Thank you, Commissioner.

ACTING EXEC. DEP. CMR. DeSANTO: Thank you.

CHAIRWOMAN YOUNG: Thank you.

Assembly?

ASSEMBLYWOMAN GUNTHER: Michael Cusick.

ASSEMBLYMAN CUSICK: Thank you.

Thank you. I'm going to just -- I'm going to follow up on the Senator's question on housing. Housing seems to be one of the bigger issues in the OPWDD community, not only in Staten Island, where I represent, but statewide when I meet with folks here up in Albany.

I see in the testimony about the housing strategy that's put forward by your agency. I just want to start with the Executive's proposal of including $15 million in capital investments to supportive housing for people with disabilities. Could you just run through with us as to how that's going to work? What's the timeline on that? And could you also -- how many affordable housing units currently exist in OPWDD?

ACTING EXEC. DEP. CMR. DeSANTO: So currently we have 4,200 people who receive some kind of housing subsidy. And within our funding we do provide housing subsidies to help people with their rental and other housing-related costs. They access housing supports of all kinds.

So they may be out there renting an apartment that's not necessarily one that was specifically created through an affordable housing funding, but many of them are also part of the affordable housing initiatives.

I can't tell you exactly the number of supportive housing apartments that are out

there today, but the way the process works is that there is a request for proposals process that we engage in, and we receive proposals from developers that are interested in creating these affordable housing units. And we have a whole review process that we engage in that looks at the proposal itself, the need in the area, and so on.

So within the coming year we will be, as we have in the past couple of years, soliciting those proposals and making those approvals for those supportive housing units to be created --

ASSEMBLYMAN CUSICK: And this is capital money to construct these facilities, right?

ACTING EXEC. DEP. CMR. DeSANTO: That's correct.

ASSEMBLYMAN CUSICK: And is there a mechanism yet in place, or is that still in the planning stages of identifying which counties will be selected for -- to dovetail on the Senator's comments, $15 million doesn't seem to be a lot, particularly for

the entire State of New York. I'm sure we could use $15 million alone in Staten Island, hint, hint.

(Laughter.)

ASSEMBLYMAN CUSICK: But that's what I'm concerned about, is how is the process going forward in identifying which counties and what areas qualify or have the greatest need.

ACTING EXEC. DEP. CMR. DeSANTO: So as we solicit the proposals, you know, we look at who is interested. And, you know, we don't necessarily get a proposal from developers in every part of the state. But we look at those proposals, what they're proposing to do, you know, how it fits in with our priorities. And there's really a whole review process that we undertake, you know, to determine where to make the investments.

ASSEMBLYMAN CUSICK: Is this in effect right now, or is that still being planned on?

ACTING EXEC. DEP. CMR. DeSANTO: For this coming year, it's in the planning

stages, but it will go forward fairly soon.

We also, as was mentioned briefly -- I think that we will be able to have our providers make applications for the $20 billion in the Affordable Housing Initiative of the Governor.

ASSEMBLYMAN CUSICK: And that was last year's -- in last year's budget, correct, the $20 million in affordable housing? How much of that $20 million is actually going to OPWDD for supportive housing for people with disabilities?

ACTING EXEC. DEP. CMR. DeSANTO: Well, it's actually $20 billion, I believe.

ASSEMBLYMAN CUSICK: Twenty million?

ACTING EXEC. DEP. CMR. DeSANTO: Twenty billion. In the Affordable Housing Initiative that I'm referring to, which is in addition to the $15 million that we were speaking of a moment ago.

And I think, when you say how much of that is available, it really depends on how the process progresses with applications from our providers. So there's not a set amount,

not a set-aside amount.

ASSEMBLYMAN CUSICK: Well, again, I know my time is running out, but I just want to stress how important this is, this issue of supportive housing for people with disabilities.

We have families, as mentioned before, who are growing older and they're frightened as to figuring out what's going to happen to their child, who is also getting older, and where they're going to live, who's going to take care of them. And I really think that we're in an emergency situation here and we need to come up with not only -- not only go through with the existing money that we're mentioning here, but we need to come up with more money.

Thank you.

ACTING EXEC. DEP. CMR. DeSANTO: Thank you.

CHAIRWOMAN YOUNG: Thank you.

We've been joined by Senator George Amedore.

And our next speaker is Senator

Kaminsky.

SENATOR KAMINSKY: Good afternoon.

ACTING EXEC. DEP. CMR. DeSANTO: Good afternoon.

SENATOR KAMINSKY: I speak to a lot of parents of children who are -- or young adults, I should say, who are no longer in school, and they're very worried about aging out and whether there will be appropriate dayhab facilities and other programs that will meet their needs. Some wait very long on waiting lists only to find that, for some reason, either the program is cut or it doesn't qualify for some reason.

I'm hoping you could tell me what assurances I could give to those parents that OPWDD is working hard to provide appropriate services for those deserving individuals.

ACTING EXEC. DEP. CMR. DeSANTO: Thank you. You know, certainly every year we work with a group of individuals and their families across the state who are graduating from school, and we work very hard to try to find out early on in the process of

transition so that we can do appropriate planning.

We have, in our new service dollars each year -- and again, thank you for all of the support we have had over the years with those new service dollars -- a percentage of that money is utilized to look at the varying needs of people leaving school. So we look to make sure that we have the right kinds of adult day supports, whether it be employment for some or for others that need a more structured kind of day habilitation experience.

But we try to ensure that we have the right services in the localities where they are needed, and our regional offices work very hard to make sure those transitions happen in a timely manner and that the services that are needed are developed and available.

SENATOR KAMINSKY: I'd love to continue to work with you on making that an even more efficient process.

When it comes to the adult housing

situation, I really echo the sentiment of a lot of my colleagues. And I think when you talk to parents who are now themselves getting older, they're really worried that if something happens to them, who is going to take care of the children that they love so much? And they're especially worried that there's going to be a gap between the time that something is ready for them and the time when, God forbid, something happens creating an urgent situation.

So I was hoping that you could address that and tell me what steps that your agency is taking to make sure that it's a much more streamlined and efficient process and that these parents can know that New York will step in if they can no longer take care of their children.

ACTING EXEC. DEP. CMR. DeSANTO: Yes, and that is the reason why we did create the multiyear housing plan that we have this year in the budget. We used a lot of information that we have gathered over a period of a couple of years that really tries to look at

where families are located, who needs the services, where we have individuals living with caregivers who are getting older, and try to factor that in in the development of the plan to meet the needs of the 6,300 over three years.

We think that's a good number, and we hope that we're going to be able to identify and work with these families over this period of years to provide them with more confidence for a more planned and timely transition and availability to residential supports. So that really is the goal.

We have heard -- as you have, obviously -- our stakeholders raising a lot of concerns. And within the plan there is the development of new opportunities in addition to the use of existing opportunities, and that's been something we have heard from families that have been concerned about the development of new residential settings that they may find to be more appropriate or more fitting the needs of their family member. So that was recognized

within the plan.

SENATOR KAMINSKY: Okay. Well, that's good to hear. And to the extent we could emphasize that more, I look forward to working with you. And whether it's on the funding end or on gathering information on what's going on in Nassau County or anything else, I look forward to working with you to make that a priority.

You know, this, to families, is the only thing that they think about when they go to sleep at night, and I'd love to help make them feel more secure, as much as I can.

ACTING EXEC. DEP. CMR. DeSANTO: Sure, we appreciate that. Thank you.

SENATOR KAMINSKY: Thank you.

CHAIRWOMAN YOUNG: Thank you.

ASSEMBLYWOMAN GUNTHER: Assemblywoman Miller.

ASSEMBLYWOMAN MILLER: Hi.

ACTING EXEC. DEP. CMR. DeSANTO: Hi.

ASSEMBLYWOMAN MILLER: I represent an area with Senator Kaminsky. And being the mother of a handicapped child myself, I seem

to attract lots of questions from peers and fellow family members that have children with special needs. And something that I've been asked a lot about is self-direction.

So I have a couple of questions about self-direction. It seems to be something that's troubling many people -- myself included, because my son is 17. So there seems to be some slowdown, for lack of a better phrase. This program, if you're lucky enough to find a Medicaid service coordinator, which there are a sparsity of, then you would have to get a broker. And from what I understand, the family member can train to become a broker, or you can hire a broker, and there is a lot of question about the follow-up of these brokers.

Obviously you would, you know, expect that you can trust a family member who's a broker, but what is the follow-up of a non-family-member broker? Are they monitored at all? Six months later? A year later? Because I've heard nightmare stories of some families who have gotten a broker and then

that broker takes their case and then that broker disappears, and their budget is never launched.

And then if you are lucky enough to get the Medicaid service coordinator and the broker, there seems to be a significant problem getting to the third step, the fiscal intermediary. And there's a moratorium -- in fact, a list came out just today of the most recent fiscal intermediaries and the moratorium placed on these fiscal intermediaries that's saying they're not taking on new cases until further notice.

So what are these families supposed to do? What are we supposed to do when we can not effectively transition our children?

ACTING EXEC. DEP. CMR. DeSANTO: So I'm sorry, you know, to hear that you experienced and that you're hearing that others are experiencing difficulties with self-direction.

We have been doing a lot of work on ensuring that the fiscal intermediaries are appropriately compensated, because there was

an issue around payment to them that we've been working on. And also trying to work together on broker services with those that are providing them.

We do have over 10,000 people who are at some point in self-direction plans and are self-directing, many of them very successfully so. So what I would offer to you is if you would want to have an opportunity for us to come and have a meeting with some families around self-direction, we have done that successfully in some other parts of the state where we have some people who are really quite knowledgeable in self-direction. We've gotten wonderful feedback when we've had those family meetings --

ASSEMBLYWOMAN MILLER: I would appreciate that. I think --

ACTING EXEC. DEP. CMR. DeSANTO: And I think that that might be a good next step, perhaps.

ASSEMBLYWOMAN MILLER: I think that would be wonderful, but I also fear that --

and this is a concern of mine personally, but I think for many families. Self-direction is wonderful for a population, but as with many things in this population of the disabled, it's not one-size-fits-all. It's far from one-size-fits-all. I happen to have a child who does not fit most, and this will not work for him. It does not work for many families.

And what happens if it is working for you very well, and then something happens? What happens if something happens to the caretaker? Or what happens if a baseline changes? There are so many variables, so many places where this can fall apart -- and then what happens?

ACTING EXEC. DEP. CMR. DeSANTO: Yeah. And I, you know -- certainly we have heard concerns of families very similar to what you're expressing.

I know that we have very actively been thinking about the type of thing that's referred to as a safety-net kind of availability for people who are in these types of service arrangements. But I would

also really just echo and reinforce what you were saying, is there really is not a one-size-fits-all approach for people.

Hopefully you're not experiencing situations where families are only given a certain option, because we really do want to look at each person's individual needs in a person-centered way and try to --

ASSEMBLYWOMAN MILLER: But when you look at the alternative, which is removing the workshops into an integrated -- which is what the state is doing -- we're not left with too much in the middle.

ACTING EXEC. DEP. CMR. DeSANTO: For -- you're saying for the day supports, when your family member might leave school?

ASSEMBLYWOMAN MILLER: So that's a scary future.

Thank you.

CHAIRWOMAN YOUNG: Thank you very much.

Senator Brooks.

SENATOR BROOKS: Thank you. Good afternoon.

ACTING EXEC. DEP. CMR. DeSANTO: Good afternoon.

SENATOR BROOKS: We've been conducting a number of community meetings in my district over the last few weeks, and in many of the meetings we have people with developmental disabilities coming forward and indicating that the county has cancelled various bus routes they were using for transportation, making it impossible for them to get to certain meetings. And in some cases their providers are unable to get to where they are, because they're individuals on reduced income.

How does your agency monitor changes in the environment as far as the elimination of transportation or other issues along those lines?

ACTING EXEC. DEP. CMR. DeSANTO: In terms of -- I'm sorry if I'm not maybe catching exactly the question. In terms of, you're saying, discontinuation of certain types of service?

SENATOR BROOKS: Well, in this case,

bus routes have been cancelled by the county, that people no longer have a means of transportation to get anyplace.

ACTING EXEC. DEP. CMR. DeSANTO: Yes, I see. Well, we provide funding within many of our service types that include reimbursement to providers for transportation. So I can't say that we directly monitor, if you will, public transportation changes, although we certainly hear about it as a service coordination function that we perform.

So what we would try to do in those instances where we become aware of a difficulty that someone may have in getting to a service is work with that particular provider of the service to see if there's a way that we can provide assistance, either through some type of adjustment to the rate that the provider receives -- you know, we try to look to see if that's a possibility, if we become aware of it.

SENATOR BROOKS: Okay. So if a municipality or a city or a county was

considered eliminating transportation that provided a service to disabled people, they have no obligation to let you know of those changes?

ACTING EXEC. DEP. CMR. DeSANTO: Not that I'm aware of.

SENATOR BROOKS: Should they?

ACTING EXEC. DEP. CMR. DeSANTO: A public transportation entity wouldn't, that I'm aware of, need to call us and say, you know, we're changing a bus route. They may, often because they know the providers that individuals are traveling to -- so that may happen informally, but I don't know of a requirement for that to happen, if it's a county or other type of transportation service.

Unless it's a Medicaid service -- I don't know if you're referring to a Medicaid type of transportation or if it's more like some other type of vendor.

SENATOR BROOKS: Well, what we ended up with -- probably a half a dozen informed me, that came forward that had disabilities,

where the bus service had been eliminated and they had no way to get anywhere.

ACTING EXEC. DEP. CMR. DeSANTO: So, you know, maybe we could be in touch with you and work on the specifics of what you're referencing.

SENATOR BROOKS: Okay. Great, thanks.

ACTING EXEC. DEP. CMR. DeSANTO: Okay. Thank you.

SENATOR BROOKS: Thank you.

CHAIRWOMAN YOUNG: Thank you.

ASSEMBLYWOMAN GUNTHER: Ellen Jaffee.

ASSEMBLYWOMAN JAFFEE: Thank you.

What did -- you raise an issue regarding similar proposals that I understand are being made revising the respite rate reimbursement, directly in discussion with many of the organizations, huge not-for-profits that really provide services. I'm truly concerned, because they believe that it would negatively impact their ability to serve the children with disabilities and for respite services.

So one of the organizations -- and

this is repetitive in terms of the many conversations I've had -- they do provide respite for children with disabilities ages about 6 to 11. Also they provide -- those are after-school programs for them. They also provide respite during school vacations for the preschool children with disabilities, before and after their programs, their special education programs. And the families truly need these kinds of services, because their childcare programs generally do not provide properly -- the care for these children. So it is an issue.

The current proposal for the rate of reimbursement for before- and after-school respite and vacation respite will be cut -- it cuts them almost $8 an hour, which is what is being proposed at this point. And -- which is significant in terms of the programs being able to be sustained. However, when they give them Saturday or Sunday respite programs, they are getting funded for that, which is very strange in how that determination has been made.

So, you know, it is really very serious. The adult respite programs also would be reimbursed at a higher rate. So the change is going to be an enormous loss of almost 30 to 40 percent in funding to these major not-for-profit organizations and force them to close programs, and the parents are then left with very little opportunities to provide that -- they're working to provide that after-school programs or even vacation programs. So it's not a luxury, it's something that really is desperately needed.

So I wanted to raise that issue. And in the conversations, I took some notes and I -- in my conversations with the organizations -- I wanted to share that concern.

ACTING EXEC. DEP. CMR. DeSANTO: Thank you for sharing it.

I'll just say very briefly that we have been working very hard to ensure that there are no interruptions to respite programs. We have heard providers' concerns about some of the changes that are happening

to the rates, and honestly, some of the rates are actually going to be better for providers.

And there are new categories of respite within our rate structure, and I think in some instances we're really working to make sure providers know which service they provide and how it fits into the rate structure.

Because we think there's also a lot of -- I don't want to call it misinformation, but people don't yet totally understand the way these respite programs are now going to be falling into categories and funded. So we have been doing a lot of work with providers, both individually and also collectively.

I think I mentioned earlier we're going to do a webinar with them again -- this is the second time, but later this week -- and we've done a lot of outreach to make sure that those providers who are concerned that they will not be able to continue to provide the service, that that, you know, does not happen.

Certainly we agree with you that it's just a crucial service and we can't afford to lose one program of respite. So we're thinking --

ASSEMBLYWOMAN JAFFEE: I also just want to follow up on the conversation earlier regarding the assistance to ensure that we have the salaries for our workers within these facilities. They're really essential. They're required to have certification, they're required to -- even the teaching assistants have to have certain certification. And their salaries are in many cases almost at the poverty level, literally.

So we need to provide that kind of funding so that these really dedicated educators in these programs are provided with the funding to be able to assure that they have the salaries to maintain them. Because what happens is they leave, they go to the public schools where they can get the health insurance as well. So -- and this is very high need areas and programs.

So I just wanted to share that in terms of the funding availability for the programs, the not-for-profits.

Thank you.

ACTING EXEC. DEP. CMR. DeSANTO: Yes. Thank you.

CHAIRWOMAN YOUNG: Thank you.

Senator Savino.

SENATOR SAVINO: Thank you, Senator Young.

Good afternoon, Commissioner.

I'm sure that you've heard from many of my colleagues about the concern about the staffing issues, so I'll try and not be repetitive. But I just want to make the point that I know for the last six years, every year the Governor's call letter to the agencies is asking them to submit their budget with a zero, a zero percent growth budget, which -- astounding enough as it is, but even in light of that, this agency somehow or other, after seven years, is spending $134 million less than it was when the Governor first took over, in an agency

that is dealing with probably the most vulnerable of our citizenry.

And now we have the added complication of the increased minimum wage. And I have said this many, many times: The fact that we even consider this work as minimum wage work is appalling enough as it is. The direct support professionals should be recognized for the fact that they are in fact professionals. And we're not taking care of widgets, we're not putting hamburgers in a bag, we're taking care of incredibly vulnerable populations.

But we're not providing sufficient resources to this nonprofit sector who we rely on to take care of our most vulnerable population, to be able to do so and to be able to retain and train and keep these direct support professionals. And the reality is that we're looking at a vacancy rate and a turnover rate in some of these agencies that just in the past two years has jumped from 7.76 percent to 11.8 percent.

Now, I can't imagine that that's not

going to get worse, the pressure on these agencies to not just meet the minimum wage. Because we're not providing sufficient funds for it is going to make it even harder.

There's the wage compression issue that they're now going to have to deal with, and I foresee a real crisis in this sector if we are not -- if we don't adequately provide funding for it.

So I'm just curious as to -- as the person who's sent here to justify the budget, how do you guys explain to the Governor's office that his demand for a zero-growth budget is, one, unrealistic for the population that you're serving here and, two, really does a tremendous disservice to the workforce and the work that they do?

I mean, as a state, we can't on one hand say that, you know, working in a fast food restaurant and taking care of the developmentally disabled are equal work. They are not. They just simply are not. And I think it's time that we recognize that and we begin to adequately provide funding for

the workforce, because if not, we know -- you know, I used to be a caseworker -- when you disrupt the workforce and you disrupt the care providers, it has a serious effect on the people that you're taking care of. If they're in occupational health and if there's a setback emotionally, there's a setback.

So I'm just curious as to how you think we're able to provide this type of service to people who really depend upon it with basically no money.

ACTING EXEC. DEP. CMR. DeSANTO: Well, you know, I would say again that there certainly is a significant investment that's made this year to ensure that we can meet the minimum wage requirements for our providers. I think that's an important step.

There is a lot of support in this budget for many types of services, and over the years we certainly have made investments in this workforce for the cost of living. But certainly we recognize and agree that the direct support professional job is a very -- it's a very demanding job, and it is critical

to the services that we provide.

So we certainly want to go forward and do everything that we can, looking at compensation and other factors, to make sure that the workforce that's needed can be recruited and that there's good retention in our direct support workforce. I think we certainly would agree with that. We'd want to work with you on that going forward.

SENATOR SAVINO: Well, I'm sure you believe that. The problem for you, I guess someone in your position, is that your agency is not making that known to the bean counters at the Division of Budget. Because they certainly don't realize -- they either don't realize it or don't believe it, or they believe that with a zero-growth budget for the past seven years that you're able to accomplish all of these things for the most vulnerable population without needing any extra money. And I don't -- I just don't think that that's realistic.

And I think that it becomes incumbent upon you and your team to convince the

Governor's office that they're wrong, that asking you for a zero-growth budget is just unrealistic, unfair, and quite frankly, it's inhumane to the population that you're serving.

So while there might be in this budget, and I think that's still debatable, the funding to provide -- I'm going to stop soon -- for the minimum wage, it doesn't accommodate for what we know is the wage compression issue for the people who are right above it. And that continues to denigrate the workforce. Because why would anybody want to stay if they can work somewhere else, in a fast food chain restaurant, and go home every day after an eight-hour shift and not have to worry about whether or not a consumer that they were taking care of is suffering or not?

Believe me, if it were up to me, I would not want to do this work. You have to worry about the Justice Center, you have to worry about the people you're taking care of. It's just -- it's unrealistic to think that

we're going to be able to recruit and retain quality people to stay in this job if we don't acknowledge the work that they're doing.

So I just ask that you and those of you who really know this work fight a little harder for the people who really, really need it. Thank you.

ACTING EXEC. DEP. CMR. DeSANTO: Thank you.

CHAIRWOMAN YOUNG: Thank you.

ASSEMBLYWOMAN GUNTHER: Assemblywoman Rosenthal.

ASSEMBLYWOMAN ROSENTHAL: Thank you.

First thing, I agree with Senator Savino, as probably all of us on this board do.

I want to ask you about START, OPWDD's increased community-based crisis intervention and prevention services for people with intellectual and developmental disabilities and co-occurring mental health and behavior health needs.

Last year the State Legislature

appropriated $50 million for the budget for START, and this year OPWDD is requesting $12 million to expand START in the downstate region. Can you describe how START is working, and maybe explain how many people have been served both upstate and downstate?

ACTING EXEC. DEP. CMR. DeSANTO: Sure. So the START program, as you referenced, is a program that assists people who have behavioral health needs in addition to developmental disabilities. And I think we've all seen that many of these individuals can have crisis situations that hopefully can be avoided through a more proactive and therapeutic approach, which is what the START model brings about.

So we began the START program both in the Hudson Valley and in Western New York. Those are the most established START entities. We went into New York City last year, we'll go into Long Island this coming year, and then, finally, we'll go back upstate to the Southern Tier and Central New York area.

I don't have the exact number of START participants; there are hundreds of them. But we do have some information to show that we are able to prevent people who had previously had to go to hospital situations to be supported when they were in crisis, we've been able to prevent that type of thing from happening. So we are seeing a lot of success as we continue to implement the model.

One of the things that we will be setting up soon are crisis centers which are actually -- you might relate to them more as respite types of settings, where people can go actually for short periods of time who need that type of ability to get away from the situation that they live in in order to become stable. So we are seeing a lot of success with the model, and we're very pleased that we'll be able to be supported to continue to move it into other parts of the state this year.

ASSEMBLYWOMAN ROSENTHAL: So it's in the five boroughs in the city, but how is

it -- how are the personnel divided?

ACTING EXEC. DEP. CMR. DeSANTO: Well, it's just this past year was when we really began to get up and running in New York City. And so I'm not sure when you say the personnel -- or how does it go about serving all of the five boroughs?

ASSEMBLYWOMAN ROSENTHAL: Right.

ACTING EXEC. DEP. CMR. DeSANTO: Yes. We have a couple of different providers who are engaged in the services there. I'm sorry, I don't know off the top of my head the number of staff that are dedicated in the boroughs, but we divided it up into two areas in New York City to be able to meet the -- what we anticipate to be the number of people who will need to be supported there.

And it's really just kind of beginning to get off the ground, so maybe we could at a later point in time report back to you on some of the -- some of what we're finding there in terms of numbers of people and their needs.

ASSEMBLYWOMAN ROSENTHAL: Right. I'd

appreciate that. Thank you.

ACTING EXEC. DEP. CMR. DeSANTO: Thank you.

CHAIRWOMAN YOUNG: Anyone else?

ASSEMBLYWOMAN GUNTHER: Mr. Santabarbara.

ASSEMBLYMAN SANTABARBARA: Yes, thank you.

I have a question about rate rationalization. We heard from a provider agency recently about their experience with the rate rationalization. And this was an upstate provider, their budget runs from January to December. In November of 2015, they were notified of an anticipated rate which would have been retroactive to July of that year. On December 31st they were notified by OPWDD that their rate was actually higher than that anticipated rate, giving them a surplus. So since the new rates are based on the previous odd-number year, when the rate for 2017 is figured from the previous odd-number year, they're going to see a different rate, a lower rate. So

they're kind of going to be penalized because of that delay in providing that information.

So I just wanted to ask, have you heard of this happening before? How often does it happen? And are there plans to address this sort of disconnect?

ACTING EXEC. DEP. CMR. DeSANTO: Yes. So rate rationalization was a move in our system that was something that CMS, our federal agency, required, which was to go to cost-based rates. And we had previously had something called budget-based rates.

With a cost-based rate, as you kind of referenced, the amount of money that you receive for a service is based upon cost reporting that you provide to the state. And then at some point in the future it's reconciled in one way or another with your actual costs, and your rate change is based upon that.

So it has certainly been a significant change for our providers in terms of how they had been operating, and it was also a significant change for New York State to be

administering the rates in this way. So hopefully we're getting to a point where we are more timely in giving providers information about the rates and how they will be changing.

They, by the way, are telling us feedback about how they feel. The process maybe could be adjusted to work better for them, and we are working with our providers as well as the Department of Health, which is actually responsible for rate setting. For our providers, we're engaged in many ongoing conversations about this, both with our providers and the Department of Health, and we have several proposals in front of us from providers as to what they'd like to see in terms of some changes to the system.

ASSEMBLYMAN SANTABARBARA: Okay. So we can look to see some changes to address this in the near future?

ACTING EXEC. DEP. CMR. DeSANTO: We are considering ways in which they would like to see us make improvements in that.

ASSEMBLYMAN SANTABARBARA: Okay.

Thank you.

ACTING EXEC. DEP. CMR. DeSANTO: Okay.

CHAIRWOMAN YOUNG: Well, I think we're all set. So thank you so much for testifying today, and we truly appreciate it.

ACTING EXEC. DEP. CMR. DeSANTO: You're very welcome. Thank you for the opportunity.

CHAIRWOMAN YOUNG: Thank you.

Our next speaker is Arlene González-Sánchez, commissioner of the New York State Office of Alcoholism and Substance Abuse Services.

Welcome. Okay, glad to have you here. We have a copy of your testimony, and you can start any time, Commissioner.

COMMISSIONER GONZÁLEZ-SÁNCHEZ: Thank you so much.

Good afternoon, Senator Young, Assemblymember Farrell, Senator Amedore, Assemblymember Rosenthal, and distinguished members of the Senate and Assembly committees. My name is Arlene González-Sánchez, and I am commissioner of

the New York State Office of Alcoholism and Substance Abuse Services, known as OASAS.

I want to begin by thanking you for your support of our mission at OASAS and for giving me the opportunity to present Governor Cuomo's 2017-2018 Executive Budget as it pertains to OASAS.

As you know, OASAS oversees one of the nation's largest addiction services systems. It includes more than 1,600 programs that assist nearly 100,000 New Yorkers on any given day. In addition, more than 336,000 school-age young people receive prevention services annually.

Before I discuss the specific details of the upcoming OASAS budget, I want to highlight what we have accomplished in the past year.

In 2016, I served, together with Lieutenant Governor Kathy Hochul, as co-chair of the Governor's Heroin and Opioid Task Force. The Task Force held listening forums statewide to hear from individuals, families, providers, and community leaders about their

local needs for combating this epidemic. With your support, Governor Cuomo signed landmark comprehensive legislation recommended by the task force to end the opioid epidemic.

Our collaborative efforts have, among other things, ended prior insurance authorization, to allow for immediate access to inpatient treatment, as long as such treatment is deemed necessary by a physician.

In addition, utilization review by insurers can begin only after the first 14 days of treatment, so as to ensure that every patient receives at least two weeks of uninterrupted care -- of course, if it's deemed necessary by a physician.

To expand access to Naloxone, we now require insurance companies to cover the full costs of Naloxone when prescribed to people who are addicted to opioids, as well as to their covered family members on the same insurance plan.

To reduce unnecessary access to opioids, we have limited initial opioid

prescriptions for acute pain to no more than a seven-day supply, with the exception for chronic pain and other conditions. To ensure that prescribers understand the risks presented by prescription opioids, part of their ongoing continuing medical education requirements will now include three hours on addiction, pain management, and palliative care.

And to improve consumer awareness about opioid risks, we now require pharmacists to provide educational materials to consumers about the risk of addiction, including information about local treatment services.

With the $25 million increase in the current year's budget, we have launched a number of new initiatives. We awarded 80 new residential treatment beds and 600 new opioid treatment program slots. We issued procurements to fund 10 new regional community coalitions and partnerships, as well as 10 new peer engagement programs and 10 new family support navigator programs. We

now have a total of 20 of each of these programs statewide. Additionally, we opened seven adolescent clubhouses and nine recovery community centers.

As you can see, we have been very busy advancing our key priorities and implementing new programs to address this crisis, but there is still much more work to be done.

The Governor's 2017-2018 Executive Budget proposes $693 million that will allow OASAS to continue to support existing prevention, treatment, and recovery services. In addition, this will allow us to expand our key initiatives by adding eight adolescent clubhouses, bringing the total up to 15 statewide; adding five new recovery community centers, for a total of 14 centers across the state; increasing treatment beds and opioid treatment capacity; and continuing to advance the Combat Addiction Public Awareness and AntiStigma Campaign.

This budget supports OASAS' ability to respond to needs identified by our constituents throughout the state, including

the opening of ten 24/7 access treatment centers and the development and planning of two new recovery high schools.

The Executive Budget also includes funding to support additional gambling treatment and prevention services. These funds come from the slot machine and gaming table fees charged to all new casinos operating in New York State.

So to conclude, Governor Cuomo's 2017-2018 Executive Budget enables us to further reinforce our treatment system, boost our statewide prevention efforts, and strengthen our recovery programs so that all New Yorkers have access to the system of care they deserve.

We look forward to your continued partnership as we advance these priorities. Thank you for your time today.

CHAIRWOMAN YOUNG: Thank you, Commissioner.

Our first speaker is Senator George Amedore, who chairs the relevant committee.

Senator Amedore.

SENATOR AMEDORE: Thank you, Senator Young.

And thank you for being here today, Commissioner. It's always great to see you.

No question that the Senate has taken a lead in the addiction issue that we face in the State of New York, and we have also focused in on the heroin/opiate epidemic, and it certainly remains a top priority.

I do have a few questions for you today about and with the current Executive Budget proposal. And as you have said in your testimony, last year, after the addition by the Legislature, we had approximately -- there was approximately $190 million that was dedicated to the heroin/opiate fight.

Now we see the Executive Budget proposing around $200 million. We also understand that last year's appropriations were not fully spent, nor are all of the programs up and running. So can you tell us which and how many of the programs authorized last year have not yet been online, made online?

COMMISSIONER GONZÁLEZ-SÁNCHEZ: I could certainly get you a list of those, but what I will tell you is that all the dollars that were appropriated have been committed.

So there may be a handful of programs that are in the pipeline. And as you know, sometimes the RFP processes really are lengthy. But for the most part, the programs are out the door. I mean, we've been very busy around the state, you know, opening all kinds of different types of support services throughout the state. But I'll be more than glad to give you the list of those that are in the pipeline. But within the next couple of months, all of the programs will be out.

SENATOR AMEDORE: Okay. Well, can you tell us how much of the $200 million in this year's budget is actually new funding, or is some of it remaining in last year's budget?

COMMISSIONER GONZÁLEZ-SÁNCHEZ: Okay. Thanks for the question and the opportunity to explain those numbers.

So the $200 million actually represents -- based on admission information

that we have of folks coming into our system in this year, we have projected that 47 percent, which comes out to $200 million of our funds for treatment, will be dedicated to treat this epidemic. That's where the $200 million comes in.

If you notice, last year the figure was 189 -- but due to some cash flow and timing issues, the real figure was 174.

So when you add the $30 million, which is the projection of how much we're going to spend more, that comes out to that 204.203 that's in the book.

SENATOR AMEDORE: Okay.

I'd also like to know when we can expect to hear the results of the initiatives that we've already put in place. Last year we had a whole array of new initiatives. Given prior years, more money added to the budget to fight addiction problems, there seems to be a lack of either finding the results -- because we continue to see reports showing more overdoses, more Naloxone being used, more admissions to the ERs with people

who have to go through the detox process.

So can you elaborate a little bit about that?

COMMISSIONER GONZÁLEZ-SÁNCHEZ: Sure.

So, Senator, I guess what I could say is that we have implemented really innovative programs, and most of them haven't even been operational for a full year. You know, some of them have been operational for a couple of months, so it's hard to tell the impact. We anticipate that by the end of, I guess, next year or this year, we will have better information.

But, you know, the peer support programs that we have put in place, which is going to be crucial to work with individuals that, you know, have been reversed, have had an overdose reversed -- instead of being sent out into the community without that additional support, these individuals will now work with that person to bring them into, hopefully, a crisis intervention center, where they could get the treatment that they need.

So it's going to take a little bit to really feel the outcomes of these new innovative models that we're putting in place. But I believe that we are going to see a great improvement in the service.

SENATOR AMEDORE: Well, we always would like to see some type of measurable results when we're talking about hundreds of millions of dollars being spent, taxpayer dollars being invested in helping the service providers and helping the peer-to-peer services, whether in the multipronged approach that we've been talking about and investing in in the state, whether it's prevention or treatment, recovery services that we haven't seen before.

This last year's budget was huge in recovery services, which I'm grateful for, and also with the law enforcement side of this issue. But we have to get to a point where it's very tangible in the forms of measuring the results so that we can best find where we should be targeting the necessary funds.

COMMISSIONER GONZÁLEZ-SÁNCHEZ: And I agree. And all I can say is that we too are very interested in -- and we are monitoring and we will document outcomes, because I agree. I mean, we have to know that we're putting monies in the right direction and in the right services. So we will do this.

SENATOR AMEDORE: Commissioner, can you elaborate a little bit and explain the recovery high schools that the Governor has proposed in the budget?

COMMISSIONER GONZÁLEZ-SÁNCHEZ: Sure. So the recovery high schools is an innovative, multiservice high school model where adolescents or young adults that are in recovery could go to continue their education in a fairly sober, safe, supportive environment where they could develop the supports necessary that they need to succeed, not only academically but also vocationally, educationally, and in the community. And that's the intent of these sober homes.

SENATOR AMEDORE: Okay, so I believe there's two being proposed, one upstate, one

downstate. But how would the state site these recovery high schools? Would there be local community input?

COMMISSIONER GONZÁLEZ-SÁNCHEZ: There will be community input. There will be local community input, SED, family members, young folks in the community. Of course, yeah.

SENATOR AMEDORE: Okay. And how would students be protected and kept safe such that these schools do not -- so that they will not become targets from drug dealers or hindered by other students in recovery?

COMMISSIONER GONZÁLEZ-SÁNCHEZ: Well, that's specifically the idea why we're calling them recovery schools. They will be in a setting where they'll be with other kids that are in recovery, there will be supports there, there will be counselors, there will be teachers -- it's not part of the mainstream school environment.

SENATOR AMEDORE: So once a student is admitted to the school, will he or she stay there until graduation --

COMMISSIONER GONZÁLEZ-SÁNCHEZ: Yes.

SENATOR AMEDORE: -- or will they return to their home school once they get to a point --

COMMISSIONER GONZÁLEZ-SÁNCHEZ: No. The idea is to stay in the recovery high school until they graduate.

As a matter of fact, there's a great model in Boston that has shown that 75 percent of the young people that have gone through the recovery school have maintained sobriety, and 80 percent have actually graduated and gone on to college. So it seems to be a very, very good model for both academic as well as sobriety in keeping -- recovery.

SENATOR AMEDORE: I want to kind of shift the topic a little bit from heroin and opiates and still stay on addiction.

We in the State of New York now are starting to see the casinos opening, as well as a new one that's going to open on Wednesday right here in the Capital Region, in Schenectady. What is your agency doing to proactively respond to the possibility of

increased gambling addiction?

COMMISSIONER GONZÁLEZ-SÁNCHEZ: So, as you well know, the Governor has ensured that we get -- this year we're getting $3.3 million from the fees that are attached to the table machines and the gaming machines, a total of $3.3 million once all the four casinos are open.

And the idea is to use that money to develop what we're calling Gambling Resource Centers, or Centers of Excellence, that will particularly work with individuals who have problem gambling issues. They will be able to do assessments, they will be able to do counseling and target in on those individuals primarily.

SENATOR AMEDORE: Okay. Well, my time has expired here, but I want to thank you for your testimony.

COMMISSIONER GONZÁLEZ-SÁNCHEZ: Thank you.

CHAIRWOMAN YOUNG: Thank you.

Assembly?

ASSEMBLYWOMAN ROSENTHAL: Okay. I'm

Assemblymember Linda Rosenthal. Thank you for being here, thank you for your work.

I'd like to say at the outset that the amount of money in the budget for OASAS is so low when there is a heroin and opioid crisis ravaging the state. And we hear all about that, that -- even in press releases, that there is such an epidemic, yet the amount of money budgeted for treatment, recovery, all of that is pitifully low. And I just want to register my shock that it continues to be so low.

And I would urge everyone to try to put more funding here. Those who have access to a lot of funding should direct it here, because this is a scourge that is killing future generations. We know that. We see kids earlier and earlier getting addicted to drugs, whether it's opiates, pills they steal from their parents' or their friends' cabinets in the bathroom, or when they graduate to heroin on the street. It's really kind of reprehensible.

So -- but thank you for your work on

this issue. I wonder if you could tell me a little bit about the development of community treatment beds. Can you tell me how OASAS determines where to place the new beds, and what types of beds are being developed around the state?

COMMISSIONER GONZÁLEZ-SÁNCHEZ: Okay. So we get input from local government, we use also statewide national data, CDC data as well as our own data that we collect from the communities, and we develop a sense of where the needs are for not only treatment beds but programs in general. That's how we actually determine where programs are needed.

ASSEMBLYWOMAN ROSENTHAL: So I've heard many stories, particularly from upstate regions where people have to travel long distances in order to access available treatment beds. Is there any form of transportation aside from, you know, their support system's car, their friend's car, their family's car, their own car? Is there any kind of transportation within the state for people who decide now is the time that I

have to go get myself to a detox center, a treatment center?

COMMISSIONER GONZÁLEZ-SÁNCHEZ: We don't have any type of transportation per se in our system, but I'll get back to that thought of something that we're envisioning doing as we move forward.

But, you know, I want to remind everyone that we do have that link on our website that now, by the way, includes all of our treatment programs. Last year when I testified in front of you, it was only including inpatient beds. Now it includes all treatment services. So that gives people an idea of where the beds are or where the treatment programs are available.

At any one time, you know, when you look in that system, you see that there is treatment available throughout the state. Now, I have to be honest and say that treatment is not always right down the block from the individuals, and that's what we also take into consideration as we move forward in doing our planning.

But to answer your question, the state does not provide any type of transportation per se. But those 24/7 centers that I mentioned -- that are part of this new initiative going forward that we're looking to establish 10 of -- will be sort of like a hub where individuals, when they are ready, when they've said "I am ready, I need treatment," they could go to that location and they will be assessed, they will be stabilized and then referred to whatever other treatment they need.

In other words, now, right now, what I've been hearing -- and I'm sure you hear the same -- as I go throughout the state is that, you know, people don't decide that they're ready to go into treatment between 9:00 and 5:00. Most of the time, it's on a Sunday at 3 o'clock in the morning, and the only thing really available is your local emergency department.

So we want to change that. And we're proposing those 24/7 -- 24 hours, seven days a week -- hubs that will provide that level

of care.

ASSEMBLYWOMAN ROSENTHAL: And where would they be located?

COMMISSIONER GONZÁLEZ-SÁNCHEZ: We're going to do an RFP, and it's going to be determined based on need. So wherever the greatest needs are, that's where we plan to develop the programs.

ASSEMBLYWOMAN ROSENTHAL: But it's 10 throughout the state?

COMMISSIONER GONZÁLEZ-SÁNCHEZ: Throughout the state.

ASSEMBLYWOMAN ROSENTHAL: Yeah. I mean, that's -- it's a good idea, but 10 is a paltry number when you look at how many people are coping with substance abuse disorders.

COMMISSIONER GONZÁLEZ-SÁNCHEZ: I agree. But, you know, we have to start somewhere.

ASSEMBLYWOMAN ROSENTHAL: Well, that's certainly true.

So we did a quick search on the dashboard to see where there were beds

available, and here are just a few examples.

Within a 50-mile radius of Rochester, there are 30 beds available. And within a 50-mile radius of Utica, there are 44 beds available. I mean, it sounds like a very small number. Can you speak to that? I mean, the dashboard is good if you meet the criteria for the open bed. But if you don't, then you have to go further, or not go at all.

COMMISSIONER GONZÁLEZ-SÁNCHEZ: Well, I guess it would help me to understand what level of treatment we're talking about. That would be helpful. I mean, the fact that we have 40 beds and 33, we have capacity within the system for treatment beds. Not everyone needs that level of care, so --

ASSEMBLYWOMAN ROSENTHAL: Okay. Can you talk a little bit about residential redesign, and how many providers have been approved and what services they're providing and where they're located?

COMMISSIONER GONZÁLEZ-SÁNCHEZ: Okay. We have a total of I want to say 26 or 29

providers that are -- can apply for this redesign. To date, I believe we have maybe 13 or 14. I don't have the numbers, but I will give them to you.

ASSEMBLYWOMAN ROSENTHAL: Okay.

COMMISSIONER GONZÁLEZ-SÁNCHEZ: The idea of this redesign is to establish a one-stop shopping in our treatment continuum. Currently people go into, let's say, an outpatient clinic. They are a residential program. They stay there and they need to be there from point A to point B.

What the redesign does is it really addresses the need of the individual once they come in the door. In other words, if the individual does not need three or four months of stabilization before they go into the next level, then they just get a month of stabilization, go to the next level, which is integration, and then work on going back into the community. It's a really patient-centered model that looks at the needs of the individual.

Currently what we do is that if a

person comes into most of our treatment programs, they have to stay there for, let's say, a year or 18 months, and they go through that same process. But there are individuals that don't need that level of care. And so that's what the redesign does. It really focuses on the need of the individual that comes in the door. It focuses on the level that they need, and then graduates the individual out of the program.

ASSEMBLYWOMAN ROSENTHAL: Okay. I want to ask you about Naloxone. Can you say where you think Naloxone should be available? For example, pharmacies have it, doctors have it, and more and more just regular people are getting access to it because you never know when you might need it.

What areas do you think need to have more access or cheaper access to the kit?

COMMISSIONER GONZÁLEZ-SÁNCHEZ: Well, I think that we're all -- the Department of Health has -- well, Dr. Zucker and myself feel that, you know, everyone -- we're aggressively out there talking about

Naloxone, and wherever people are interested, we are there to do the training. So if it was up to me, I think Naloxone should be available to everyone and anyone who wants it and who may need it.

ASSEMBLYWOMAN ROSENTHAL: Okay, I see my time is up. That's it for right this moment. Thank you.

CHAIRWOMAN YOUNG: Thank you, Assemblywoman.

Commissioner, I had a few questions. As you know, last year the Governor's proposed budget had $164 million in funding for the heroin and opioid crisis, and the Legislature worked with the Governor in the final enacted budget to increase that amount to $189 million.

Could you please provide a clarification, because I didn't really hear it when Senator Amedore was asking. The Governor is characterizing in his budget that there's $30 million in new programming. It's not clear what's new and what's being carried over and being billed as new from 2017. I

believe that Senate Finance has asked for a clarification a few weeks ago; we haven't received it yet.

So could you please tell us today which programs are new and which ones are existing or being expanded on?

COMMISSIONER GONZÁLEZ-SÁNCHEZ: Well, so I -- in my testimony I indicated the clubhouses, the peer support programs, the prevention, the recovery support services --

CHAIRWOMAN YOUNG: Weren't those in the 2017 budget, though?

COMMISSIONER GONZÁLEZ-SÁNCHEZ: Part of them were, yes. And then we added additional ones in this past year.

But what I could do is provide you a list that will show you exactly where we are, which is what I agreed to do with the Senator, so that it's clearer what programs are in the works and which have already been operationalized.

CHAIRWOMAN YOUNG: Thank you.

How many people have been served so far in the programs from the increased

funding that we provided last year? Or this year, 2017.

COMMISSIONER GONZÁLEZ-SÁNCHEZ: I don't have that number, but I will get that to you.

CHAIRWOMAN YOUNG: Okay, thank you.

The Governor also proposes that the increased funding will be used for 10 new regional 24/7 urgent access centers that offer substance abuse disorder services, and the formation of 10 new community coalition programs. There was a federal grant for the community coalition programs that was awarded in 2014 for 10 counties. Just to be clear, is this that federal funding, and it's been held off and now it's finally being utilized? Or is this new funding?

COMMISSIONER GONZÁLEZ-SÁNCHEZ: No, this is new funding.

CHAIRWOMAN YOUNG: Okay. Thank you.

You've launched the overdose prevention kits and Combat Heroin and Talk to Prevent campaigns. Can you explain how you're measuring the effectiveness of the

campaigns? You know, are you tracking websites, unique individuals, people taking action? How are you --

COMMISSIONER GONZÁLEZ-SÁNCHEZ: So there's a couple of ways. I mean, it's a little tricky to get actual data, but what we do is we track how many hits we get on our website. We also have the HOPEline that really usually gets a lot of the referral calls, and we monitor those calls.

And we also monitor by word of mouth what people are telling us. You know, I walk around and people say, We've been seeing the campaigns, your PSAs, you know, in the theaters, on the radio. It's really working, people are really coming out, opening, they feel comfortable -- so there are various ways that we are monitoring the effectiveness of the campaign.

And I have to tell you, you know, I really feel that the campaign has made such a huge difference. I don't know if you feel the same way as you see it, but you know, recently there's been a large number,

primarily of parents that before would never come out and talk and say, My child -- or my loved one, or my husband, my sister, whoever -- has a problem. I've been getting more and more of those calls. Confidentially, of course.

But I think it's because the campaign is out there and people are getting to understand that there's no reason why you should be ashamed. This is a disease, and we're here to help. So a lot -- some of it is a little anecdotal, but we do have some numbers, and if you would like I will share that with you as well.

CHAIRWOMAN YOUNG: I'm glad to hear that. And generally -- oftentimes agencies provide a report to the Legislature on results of certain funding or programming that we're doing, so I don't know if there's something you could do along those lines so that we would have that information. That would be helpful.

The other thing is I represent a very rural area, and access to services is always

a challenge. I was at a school a few months ago to honor the football team, and the kids said to me, very matter-of-factly, "Another one died last week." Meaning one of their classmates died from an overdose. And it was horrifying, because it's gotten to be so routine for them.

But you talk about stigma and that sort of thing. It's the feeling, in the rural counties especially, that the figures are severely underreported. And I think it's for a variety of reasons as to who's actually dying from overdoses. It is a stigma. Maybe there's -- maybe the overdose caused heart failure, and it's being reported that way rather than a drug overdose. Maybe it's the families don't want to have that.

But, you know, in Cattaraugus County we had a meeting a few months ago, and they were talking about a very low figure of people actually dying from overdoses. So is there any other way that we can have more accuracy in what's being reported?

COMMISSIONER GONZÁLEZ-SÁNCHEZ: Well,

as you know, the Department of Health is the one who gets and coordinates that data. I think that's a question that we should talk to Dr. Zucker about.

CHAIRWOMAN YOUNG: I know we also think, you know, that the days of silos -- but especially for a crisis like this -- that it should be your agency and the Department of Health working together on these issues.

COMMISSIONER GONZÁLEZ-SÁNCHEZ: And I didn't want to give you the impression that we weren't. We are. But the issue of not being reported -- I think there may be some lag time in the reporting, and the one who's really looking at the accuracy of the report is the Department of Health, which is why I raise that.

But yes, we work hand in hand with the Department of Health to get the data. But I think it may be a good thing to raise with Dr. Zucker, he may have additional information that I don't.

CHAIRWOMAN YOUNG: When your agency is deploying resources for certain programs, do

you look at that data as to how you make decisions on where funding should go?

COMMISSIONER GONZÁLEZ-SÁNCHEZ: Yes.

CHAIRWOMAN YOUNG: Okay. So that's why it's so crucial, and that's why I'm raising it. So I think that getting everybody on the same page would be very helpful. And I appreciate you saying that DOH, they understand that. But I think we've got to work together on these issues.

So thank you.

COMMISSIONER GONZÁLEZ-SÁNCHEZ: Thank you.

CHAIRMAN FARRELL: Mr. Oaks.

ASSEMBLYMAN OAKS: Yes, thank you.

One of the things that we're seeing, just to follow up some on Senator Young's questioning related to the opioid crisis that we have, is finding that some of the ambulance providers and other first responders who now have been given or have access to Narcan so that they can provide that to individuals who might overdose -- the costs of that are escalating as we're seeing

more use of that.

And so I guess the question would be, then, are your resources coming from the state which we budgeted last year, are those being used for those purposes, actually of reimbursing or providing the Narcan to those providers?

COMMISSIONER GONZÁLEZ-SÁNCHEZ: Yes, absolutely. We do -- on our own do a lot of training through our addiction treatment centers, our own facilities, and everyone that comes to the training leaves with a kit. So yes, we continue to support those kits, yes.

ASSEMBLYMAN OAKS: After they're used and if there's ongoing issues, for instance, an ambulance might come into contact with that a number of times -- after they've been trained and stuff, are those costs then back on those individual departments? Or is the state involved in reimbursing them?

COMMISSIONER GONZÁLEZ-SÁNCHEZ: Again, that would be a question for DOH, because this is where the dollars are. The Narcan

kits are there, so I would think that that would be an -- and if it involves ambulances and hospitals and EMTs, it would be under DOH, not under my department.

ASSEMBLYMAN OAKS: Thank you very much.

SENATOR KRUEGER: Senate?

Senator Kaminsky.

SENATOR KAMINSKY: Good afternoon, Commissioner.

I'd like to echo the sentiments of a lot of my colleagues. I'm in Nassau County, in Long Island, and it's -- we're in some very troubling times. The quick anecdote that I like to tell, because it so succinctly sums up the problem, is there's a principal of a local middle school who's maybe a year older than me -- so in the scheme of things, hasn't been around all that long -- and she told me that she went to the funerals of three former students over a previous summer. So we're really struggling with this crisis, and we look forward to continuing working with you on that.

Along those lines, one of the issues we hear from a lot of our first responders in my area -- that's for the most part volunteer firefighters and police officers -- is that they're administering Narcan -- so for example, the City of Long Beach, where I'm from, had about 40 separate incidents where Narcan was administered last year. Many times they're giving Narcan to the same person over again, and no one is really sure once it's administered what then happens to the person, what then happens to the patient.

In other words, are they then enveloped in some type of system that will guarantee them some type of access to treatment or support going forward? And so we're definitely encountering people who need help in the very first and obviously most critical incidents, and I'm worried that we're losing connection after that.

And I'm wondering if you could talk about what your agency is doing to ensure that we're able to not just save people when they're in the most urgent need, but get them

to the healthy recovery that we're hoping for.

COMMISSIONER GONZÁLEZ-SÁNCHEZ: So thank you. So that's what the peer navigator program is all about. It's about having peers working with the local emergency departments in a particular region so that when an individual is brought into the emergency room after having been reversed, that peer is automatically called. And then that peer will start engaging the individual during the 12 to -- six or 12 hours that that individual is in the hospital being stabilized.

Traditionally what happens is they stabilize the individual, they may or may not give them a referral to a treatment program. The reality -- we know the reality, that individual is not thinking about going into treatment, he's just thinking about where am I going to go and get my next hit, because they don't want to go through withdrawal.

So that's why the peer is so important. The peer will then engage that

individual, it would be that warm handoff that will get that individual into a crisis intervention setting and work with that individual to convince that individual to go into treatment rather than to go back into the neighborhood and we know what happens.

SENATOR KAMINSKY: Certainly on Long Island I would encourage us to meet more, especially with the emergency room providers, the hospitals -- I'm not really sure at this very moment that they are up to speed on what they should be advising people, and I am hearing firsthand from some people in the emergency rooms that people are just kind of being discharged and kind of walk out into the night.

So I'd love to work with you on getting people together and making sure everyone knows where they need to be.

COMMISSIONER GONZÁLEZ-SÁNCHEZ: Absolutely. Thank you.

SENATOR KAMINSKY: One great thing I think that your agency has done is provide local funding for the different community

coalitions. And I say all the time that it's a problem that can't be -- you know, I used to prosecute narcotics cases. We can't prosecute our way through this. It's going to take everybody pulling together -- our churches, our schools, our community leaders, student involvement, and certainly law enforcement too. And you have provided really nice grants to have these community coalitions.

So down by me, whether it's Long Beach or Rockville Centre, you are getting religious leaders, school leaders, students, law enforcement all together around the room to figure these problems out. And I think it's tremendous. And you definitely see certain communities grappling with this better than others, and I appreciate that and hope you make them more available and widespread, because a lot of communities would love to avail themselves of that resource.

COMMISSIONER GONZÁLEZ-SÁNCHEZ: We're thinking of expanding as well in this coming

year, so thank you. It's great to be --

SENATOR KAMINSKY: Sure. And lastly I do want to especially point out that this is a critical area that has had good bipartisan collaboration, and needs to.

So first of all, I want to thank Senator Amedore and Senator Akshar, who -- on either side of me today -- certainly Senator Boyle on Long Island. You know, there's not time for partisanship here. We're drowning, and everybody needs to pull together to help here. So we all need to work together.

Please count on me as a resource for whatever your agency needs, whether it's information or anything else, and I hope we can all work together to fight this. The worst part of my job so far has been talking to parents who have lost loved ones, and they tell you about those last moments. And if you're not moved by that or you're not willing or resolved to do everything you can to fix the problem, then you don't belong here.

So I want to try, and I'd like to work

with you to continue to do that.

COMMISSIONER GONZÁLEZ-SÁNCHEZ: Thank you.

CHAIRWOMAN YOUNG: Thank you.

CHAIRMAN FARRELL: Thank you.

Assemblyman Cusick.

ASSEMBLYMAN CUSICK: Thank you, Mr. Chair.

Commissioner, it's good to see you. I want to first thank you and your team for being on Staten Island many times. You're no stranger to the folks I represent and the people on Staten Island and to the issue of the opioid and heroin epidemic that's going on throughout the state.

But in my district and throughout Staten Island, it's been -- you've worked with all the elected officials, and the Governor's resources have been very helpful. And I just wanted to publicly acknowledge that, because it's important that people know that we need people in government to help us in this epidemic.

My colleagues have talked about the

funding and where we're going with a lot of these numbers. I wanted to ask a question on treatment. Treatment is a big issue. I think that treatment is the important cog in this fight against the epidemic. We have many qualified treatment facilities throughout New York State, New York City, and many dedicated professionals in that field.

A question I have for you is particularly after we cut down on the usage of opioid pills, prescription pills, with I-STOP and the increase in heroin use -- are there numbers that we know of, has there been an increase in people seeking treatment in the last year or two?

COMMISSIONER GONZÁLEZ-SÁNCHEZ: Actually, our data has shown that people seeking services, inpatient services, have increased for heroin and opioids and actually decreased for all the other substances. So yes, we have seen an increase in people.

ASSEMBLYMAN CUSICK: So we have seen it working --

COMMISSIONER GONZÁLEZ-SÁNCHEZ: Yes.

ASSEMBLYMAN CUSICK: And we have seen the --

COMMISSIONER GONZÁLEZ-SÁNCHEZ: Yes, absolutely.

ASSEMBLYMAN CUSICK: That's very important. I know that many of my colleagues have been talking about seeing that the funding that we put together is working, and that's what I'm very interested in knowing, is are people seeking treatment and are people using it. And that's good to hear.

On that point too, one of my colleagues brought up -- a couple of my colleagues brought up Narcan. And Narcan has been used as a tool -- particularly there are many overdose cases in our borough and throughout New York City. The question on Narcan is how many folks who are administered Narcan, how many of those -- are there numbers that are available that show how many of them then go to treatment after they are saved from an overdose?

COMMISSIONER GONZÁLEZ-SÁNCHEZ: I could see if we have that data. I'm not sure

right now if we actually do, but I will certainly be collecting that. I mean, that's something we need to be looking at, and certainly moving forward we are going to, so --

ASSEMBLYMAN CUSICK: Right. Because again, I think it was my colleague Senator Kaminsky that brought up that there are many people who are being administered Narcan many times, and I think it's -- we need to know how many folks. Because we all know, and we have -- on Staten Island, we have many of these Narcan training events, and hundreds of people come because it's mainly parents of families who are scared to death. But we point out that this isn't -- this saves them from the OD, but from that point they need to go get treatment.

And so I think if you could get us those numbers, that would really be important to us, particularly in this budget process coming up.

COMMISSIONER GONZÁLEZ-SÁNCHEZ: I think moving forward we'll have better

numbers because that's exactly what the peers will be doing. And as you know, the peer program has just started to become operational.

Certainly we could get numbers from the EDs where they say, you know, we've released them and we've given them a referral. The question is not so much the referral, the question is if they make it to the referral. So that's where the peers would be ideal in collecting that data.

ASSEMBLYMAN CUSICK: And I just want to add to the chorus here that the Senate and the Assembly and the Legislature, in adding money in last year's budget, I've seen the dividends, I've seen the product of it.

We just opened up an adolescent clubhouse in Staten Island. You've been out on Staten Island, there have been many roundtable discussions, but there is a strong need for more funding. And I will urge my colleagues -- I don't think there needs to be much urging, but we will fight for more funding.

Thank you.

CHAIRWOMAN YOUNG: Thank you, Assemblyman.

Senator Krueger.

SENATOR KRUEGER: Good afternoon, Commissioner.

So I represent a section of Manhattan, and my district has a task force working with the police department and the Department of Homeless Services to deal with street homelessness issues. We hear constantly from the police and Department of Homeless Services that there are homeless people who need drug treatment who ask for it, who say, Yes, I'll come in off the streets to go to it, and they rotate through a three-day detox and they can never get a slot in a residential drug treatment program.

Now, these are going to be Medicaid-eligible people, not private insurance, and they're going to be people who historically probably had a lot of trouble getting any kind of medical records because they are in fact homeless and on the streets.

There is often an overlap between mental illness and substance abuse for people on the streets. Both agencies are begging, How do we get these beds that we need if you're a street homeless person in New York City?

So you have funds for new residential programs, you have a commitment to help people with longer-term residential treatment when the short-term models aren't working. How do I get these folks into treatment?

COMMISSIONER GONZÁLEZ-SÁNCHEZ: So to that I'd like to say that we are working hand in hand with the Department of Homeless Services in New York City, together with OMH and ourselves, to identify shelters.

I believe there are a number of shelters that have been identified as high-needs shelters that do have a high number of mentally ill and addiction individuals. And we're in the process of developing or -- not developing, we are working through the process of assigning shelters to our community-based organizations. As a matter of fact, I'm

going to say two months ago or so I had a big meeting in the New York City office where I brought our community-based providers, our addiction community-based providers, together with the shelter operators so that they could get to know each other so that when an individual appeared at the shelter that needed our services, that they knew who to communicate with, whom they could reach out to.

And so, you know, we have just started establishing that relationship. Because I've been hearing that, you know, there are homeless individuals that need SUD services -- but interesting enough, the shelters didn't know that we had community-support SUD providers that were there to provide that service. So --

SENATOR KRUEGER: So I'm still confused. So this is -- if someone goes into a shelter, they can get referred into one of your residential facilities?

COMMISSIONER GONZÁLEZ-SÁNCHEZ: We have -- what we have is community-based

providers that will either go out into the shelters to do assessments off-site, because now we're able to go out of the four walls of the clinic and do assessments, and if we find that there are people that are appropriate for clinical treatment services, we could refer them and treat them because of Medicaid and so on and so forth.

So we have identified individuals that will be, for the lack of a better word, attached to a particular shelter, and they can go once, twice -- you know, I don't know the details of how often they'll go to the shelters and do the actual assessments of individuals and identifying the individuals that may need additional care and engage them to go into care.

SENATOR KRUEGER: Okay. So I think we're talking about two different populations. Because if you're somebody who is homeless and in the shelter system, there may be one pathway. But there are enormous numbers of people who are homeless on the streets who will not go into the shelters

because of the combination of being mentally ill and substance abusing.

So the Department of Homeless Services has a separate system of outreach workers who coordinate with the police precincts, and those people don't seem to be getting any access to residential treatment.

COMMISSIONER GONZÁLEZ-SÁNCHEZ: Okay. So I need to be made aware of where, who, and -- who they are. Because we too are having -- we do outreach as well, now. The peers are also going out and doing outreach to the people in the street, like you say, not people in shelters, people especially around the 125th Street area, that whole area, doing outreach to actually engage some.

But if there're others, please let me know. I'll be more than glad to see how we could be helpful.

SENATOR KRUEGER: Great. So you have people who can come out, work with the outreach teams and the police, and direct people into treatment who say they want it?

COMMISSIONER GONZÁLEZ-SÁNCHEZ: We

have providers that will be able to do that, yes.

SENATOR KRUEGER: So the peer counselors, I think that's the term you use, they actually have the authority to move people into treatment slots?

COMMISSIONER GONZÁLEZ-SÁNCHEZ: They don't have the authority to move them, they have the ability to engage them and get them to agree to come into treatment, and then we will provide the treatment that they need.

SENATOR KRUEGER: Okay. So yes, I would love to know who in your office can coordinate with us on the --

COMMISSIONER GONZÁLEZ-SÁNCHEZ: Absolutely.

SENATOR KRUEGER: We actually have people who say, I want this, and nobody can get them in -- not Department of Homeless Services, police department, nobody. So we want that access.

COMMISSIONER GONZÁLEZ-SÁNCHEZ: Great.

SENATOR KRUEGER: Thank you.

COMMISSIONER GONZÁLEZ-SÁNCHEZ: Okay.

CHAIRWOMAN YOUNG: Thank you.

Anyone?

CHAIRMAN FARRELL: Assemblyman McDonald.

ASSEMBLYMAN McDONALD: Thank you, Mr. Chair.

And Commissioner, thank you for your great work. You and your team are always very responsive to our needs. And, as I always say, it's very difficult to catch the wave when it's already been three or four feet ahead of you. So we're working on it, day by day and program by program.

I think Member Rosenthal kind of started to get into this, and you -- I think you called them hubs, these urgent access centers?

COMMISSIONER GONZÁLEZ-SÁNCHEZ: Yes.

ASSEMBLYMAN McDONALD: So I'm not terribly familiar with them. Are they currently in place in the state?

COMMISSIONER GONZÁLEZ-SÁNCHEZ: No. This is a brand new model that we're introducing as part of this Executive Budget.

ASSEMBLYMAN McDONALD: Okay. I remember -- is that what you were mentioning as the hubs to --

COMMISSIONER GONZÁLEZ-SÁNCHEZ: Yes.

ASSEMBLYMAN McDONALD: Okay. And I remember you saying that, you know, that's going to be statewide, you're going to put up an RFP to kind of see where the need is, and then hopefully that will work out.

I guess the question is, do you envision this being run by -- who are the eligible entities? Is it a nonprofit, is it a hospital system, is it a medical practice? Do we have an idea of what it would be to --

COMMISSIONER GONZÁLEZ-SÁNCHEZ: We don't limit it, but I think the -- I think we would like it to be a community-based provider, but it's not limited to a community-based provider. We're welcome to see what proposals or responses we get. Different areas may have different needs, may have different setups, so we don't want to limit any of the options that we have in place.

ASSEMBLYMAN McDONALD: So is there going to be -- and so I imagine it will be not only for a physical site but also staffing?

COMMISSIONER GONZÁLEZ-SÁNCHEZ: Oh, yes.

ASSEMBLYMAN McDONALD: Right? Obviously. And is there going to be any minimal clinical requirements for like a nurse to be on duty? Or is it just going to be clinical coordinators, is it going to be social workers --

COMMISSIONER GONZÁLEZ-SÁNCHEZ: Well, it's going to be a clinical model. So, you know, we'll develop the model as we go along. But if it's a 24/7 urgent care, I don't know that you're going to require to have an MD on site.

ASSEMBLYMAN McDONALD: Right.

COMMISSIONER GONZÁLEZ-SÁNCHEZ: But there will need to be access to an MD in the event that you get an individual at three in the morning that has to be stabilized, or a nurse practitioner or a physician assistant

as we move forward. So it is going to be a clinical model, but it's also going to have other kinds of supports as well.

ASSEMBLYMAN McDONALD: And I imagine it could be, you know, there are real -- in the other medical world, there are urgent care centers which are kind of like more a family practice or primary -- you know, emergency but not an emergency room.

Would they be excluded from that? Or would they be able to -- or has that not gotten that far enough down the road yet?

COMMISSIONER GONZÁLEZ-SÁNCHEZ: You know, I haven't thought about that. But, you know, we have to look at the model and see. If it works in certain areas because of the limitation of the providers or the limits of what we have in place, it may not be a bad idea.

Right now we're not excluding anything. We're open to proposals.

ASSEMBLYMAN McDONALD: Good. Thank you.

As you mentioned earlier in your

testimony, there's a lot of different impacts from last year's legislative session. One was a leaflet that pharmacies are required to give patients which is very complete, it covers -- it's a great collaboration between your agency and the Department of Health as to really the dos, don'ts, the wants and needs.

You know, one of the things that I've always harped on is that the heroin epidemic has been fueled by legally prescribed opioids that are in the households. And that is part of the information that's on those leaflets, which is good.

The question that comes up is, patients many times are saying, Well, what do I do with this? How do I dispose of them? And as we all know, pharmacies can take them back. A lot are hesitant to, because you have to worry about reverse distribution of the drugs, the whole nine yards. Are there any programs that are being supported through OASAS to assist the community or the community pharmacies or healthcare providers

to help facilitate disposal of legally prescribed prescription drugs, to get them out of the waste stream? Because as we know, 70 percent of heroin addicts started with those prescriptions.

COMMISSIONER GONZÁLEZ-SÁNCHEZ: No. OASAS does not, but I understand that maybe DOH may, because this really does fall under their jurisdiction. But we currently do not.

ASSEMBLYMAN McDONALD: Okay. Thank you.

COMMISSIONER GONZÁLEZ-SÁNCHEZ: Thank you.

CHAIRMAN FARRELL: Thank you.

CHAIRWOMAN YOUNG: Thank you.

So just -- we can go through the lineup. Next is Senator Krueger. Wait. Senator Brooks, that's right. Senator Brooks, then Senator Akshar, and finally Senator Ortt.

So Senator Brooks.

SENATOR BROOKS: Thank you.

First, to a point that's been made by a number of the members, I think the problem

is being greatly understated. As a first responder, we're seeing it on an ever-increasing basis, and there are a number of cases where we have people that we're visiting multiple times. I think it's important that we really get a handle on how big this problem really is if we want to address it and if you're going to prepare a budget that's going to address the problem itself.

But I think it really is still hidden in many cases, and a lot of attention has to be given to quantifying just how many cases are out there.

But to move to a different area for a moment, can you address programs that you're currently undertaking to address veterans in terms of problems with substance abuse?

COMMISSIONER GONZÁLEZ-SÁNCHEZ: So we currently do have a variety of veteran-specific programs. Off the top of my head I can't tell you exactly where they are, but we do have programs that are specific to do treatment and also recovery services. But

I must say that all of our programs, all of them, serve veterans.

I mean, if we have -- we ask the question "Who do you serve" as part of the data that we collect on a regular basis, and often all of the programs seem to have several veterans in there.

So we do have programs that are specific for veterans. Also, for women vets, we have at least two residential treatment programs for women vets. And we also have for males, but I don't have them off the top of my head. But --

SENATOR BROOKS: Well, when you have reports that, as you put it, all of them involve veterans, isn't that a signal to you that you need to look at that group and concentrate on what's happening with them? The fact that they appear on every report to me would suggest that you might want to have a program that's geared at that segment of our society directly.

COMMISSIONER GONZÁLEZ-SÁNCHEZ: And we do, we do have -- and I'll be more than glad

to share the number of specific vet programs that we have in the system. But I think, and maybe I'm opening a can of worms here, there is an issue with TRICARE where veterans can go and get their treatment, and that usually hampers veterans coming to our system, because the military won't pay for the services.

But setting aside from that, we do have specific programs for vets. And if you'd like to get a list, I will be more than glad to give them to you.

SENATOR BROOKS: Okay. Thank you.

CHAIRWOMAN YOUNG: Thank you.

Assembly?

CHAIRMAN FARRELL: Assemblyman Santabarbara.

ASSEMBLYMAN SANTABARBARA: Yup thank you.

Just a quick question about some concerns of doctors not having training or time with the increased amount of treatment they've had to do with opiate use. I just wanted to ask if we were keeping track of how

many doctors are actually authorized to prescribe the medication for assisted treatment.

COMMISSIONER GONZÁLEZ-SÁNCHEZ: If we have a number -- I believe we do, yes.

ASSEMBLYMAN SANTABARBARA: And is that something we could find somewhere, that you can report to us?

COMMISSIONER GONZÁLEZ-SÁNCHEZ: I could give you that report.

ASSEMBLYMAN SANTABARBARA: All right. Thank you.

COMMISSIONER GONZÁLEZ-SÁNCHEZ: You're talking about doctors in our system? Or outside of our system?

ASSEMBLYMAN SANTABARBARA: Actually, both would be good, just to keep track of how many people are actually authorized to prescribe the medication needed.

COMMISSIONER GONZÁLEZ-SÁNCHEZ: Okay. Sure.

CHAIRWOMAN YOUNG: All set?

Okay, Senator Akshar.

SENATOR AKSHAR: Great, thank you,

Madam Chairwoman.

Welcome, Commissioner. It's always a pleasure to be with you, and I publicly want to thank you and your team for being so receptive when we have issues in the Southern Tier.

Let me start with community-based providers. You're very familiar with Fairview Recovery Services in the Southern Tier. And are we addressing the cost-of-living adjustment anywhere in the Executive's proposal? Fairview, for an example, has had a 70 percent, 70 percent turnover in 2016 because of the low pay. Are we dealing with that issue specifically?

COMMISSIONER GONZÁLEZ-SÁNCHEZ: Well, Senator, there's no cost-of-living increase in any of the budgets. There's no reason why it would be in my budget.

So the answer is no, we don't have a cost-of-living increase or a cost-of-living adjustment in our budget. You know, I do want to emphasize the fact that we understand and we take our workforce very seriously.

It's not to say that we undermine the work that they do, that we don't value the work that they do. It's quite the contrary, especially in the addiction system.

But at the same time, the Governor has put in millions of dollars in the budget to address the minimum wage. And I understand that the minimum wage and what we're talking about, the cost of living, are somewhat different from where I stand. We in our system have $5 million that was put in to address the minimum wage in our community-based organizations.

So what that is telling me that's currently -- even with the COLA adjustments that we have had, as you've heard, you know, in the last three consecutive years there's still -- it's quite -- there are still quite a few people that are doing way below the minimum wage in our system of care. So, you know, I support the fact that these individuals have to be brought up to the $15.

With respect to the cost-of-living adjustment, what I could say is that, you

know, I will continue to monitor the agencies, work with the agencies, as I have done in the past, to ensure that they can still function within our parameters. And I look forward to continuing my discussion with the Legislature with respect -- you know, in the context of the budget discussion.

SENATOR AKSHAR: Thank you.

What happened to the Technical Assistance Unit that used to help providers with documentation compliance? One thing I hear from providers is that, you know, the regulatory requirements are somewhat difficult and OASAS doesn't provide case model documents that accompanies the new regulations. Do you do that? Am I being given good information?

COMMISSIONER GONZÁLEZ-SÁNCHEZ: Well, I'm not sure that's accurate information. I mean, if there's anyone that needs technical assistance, we're there to give technical assistance, so --

SENATOR AKSHAR: Do you still have a particular unit called the Technical

Assistance Unit?

COMMISSIONER GONZÁLEZ-SÁNCHEZ: Not per se. But our field office will be able to assist.

SENATOR AKSHAR: Let me ask a question about Narcan that's been brought up by several of my colleagues. I, for one, am a proponent of ensuring that there is more than enough Narcan in the community. Senator Young mentioned statistics being underreported.

Is there somewhat of a concern that, you know, first responders are required to fill out certain documentation so we know it was deployed, on whom -- because we're putting so much Narcan into the system, could we be underreporting statistics? We have to set some form of benchmark in order for us to determine whether we're successful or not, right?

COMMISSIONER GONZÁLEZ-SÁNCHEZ: Right. I agree. And again, I think that's a question better suited for the Department of Health, as they are the ones that get the

actual documentation.

SENATOR AKSHAR: Okay, let me make just two more points, if I may. I just want to publicly bring up retrospective review, as we've discussed in our conversation last week. I just want to put that on the radar and ensure that it stays on the radar and that we do our due diligence in ensuring that insurance providers are not abusing that, because the last thing I'd want to see is healthcare providers being reluctant to provide that service that we're working so hard --

COMMISSIONER GONZÁLEZ-SÁNCHEZ: Absolutely. And that's what we're focusing on this coming year, to really look and make sure that all the regulations that have been put into place are being implemented. And like I said to you, if you get any actual cases, please report them to us.

I think what's been happening is that sometimes the providers also do not submit enough information to the managed care company, enough so that the managed care

company can make a true evaluation and determination of the case, in which case then they will say, Okay, so now I'm going to go retroactive.

So I think we need to be open to both sides and we need to monitor that both the insurance managed care company as well as the providers are doing each their share. And like I said, if you find instances where that is occurring, please let us know. We would like to intervene immediately.

SENATOR AKSHAR: Thank you. I know my time is up. I have one last question, if the Chairwoman would be so kind.

The Criminal Procedure Law allows for asset forfeiture, and a portion of that asset forfeiture by law enforcement requires a portion of that money to go into the Substance Abuse Services Fund. My question is two parts. Do you know how much money is currently in the Substance Abuse Services Fund? And if so, what is it?

And then the second part of my question is, how much money in this year's

executive proposal for OASAS is coming from the Substance Abuse Services Fund?

COMMISSIONER GONZÁLEZ-SÁNCHEZ: So the first question is, you know, the actual amount fluctuates from year to year, based on court proceedings and what happens in the courts.

And in terms of how much money comes into OASAS, we fund our campaign out of that, we do some of our peer supports, we do some of our SBIRT interventions. I don't have the exact number, but I will try to get that number for you.

SENATOR AKSHAR: The only reason I ask is because, you know, obviously we have such a major issue. It's an epidemic, that we all agree upon, and there's no sense in leaving money sitting in that account if we don't have to. In my humble opinion, we should be spending it.

I want to thank you for your service and all your work on this issue. It's incredibly complex, and if there was a simple answer, any one of us up here or you or your

team would offer to solve it. I agree with Senator Kaminsky, it's a community issue that requires a community's response. I think we're there, we're all headed in the right direction, and we need to continue to do that.

So again, I publicly thank you for everything that you're doing.

CHAIRWOMAN YOUNG: Thank you, Senator.

Senator Ortt.

SENATOR ORTT: Thank you very much, Commissioner. I think I'm last, so I'll try to be brief because I know we still have several other speakers who have to go through.

First of all, I want to thank you for your assistance over the last two years, because I served as a co-chair of the task force, going around the state, doing a lot of good work, having a lot of good conversations, some of them challenging. But I want to thank you for your assistance.

You know, it's more of a statement, and maybe you can offer a response. I know

it's been brought up already a little bit, but I think it's important to note, when you leave here today, one of the real challenges that I feel as a legislator and that I hear from a lot of folks in my district and across the state is when it comes to the beds and the funding for the beds, and even funding for in-community -- you know, supports in the community or services in the community, many of these seem to exist on paper, but they're not getting -- whenever I talk to folks in the community, they're still having a hard time getting into inpatient treatment.

And so while we can point to these beds and the existence of these beds and the existence of this funding for it, you know, I'm a big believer that if it's not -- if people aren't seeing it, if it's not getting to the areas that it's needed, then it's almost like it didn't happen.

And so I just think it's very important that we get these funds out the door as soon as possible and get these beds online as soon as possible. Because you

certainly understand that there is a list, a waiting -- you know, a waiting tide for these services as we sit here and speak today.

I don't know if you want to comment on that. If not, that's okay.

COMMISSIONER GONZÁLEZ-SÁNCHEZ: No, I guess what I would say is I agree 100 percent, and that's what we have been trying to do.

In terms of some treatment programs in certain areas, you know, we have a big challenge with community opposition which, you know, I didn't raise. But, you know, I really need to raise it, because that's a reality for a lot of the things we do.

Just this past year, trying to open certain programs in certain areas was really extremely difficult. So I just want to put it in the context that of course we want to get the services out, that's what we're interested in. And we will continue to try to do that to the best of our ability.

SENATOR ORTT: Is this budget -- and it may have been touched on; I don't think it

was. You know, across the state there's been programs -- I know it was mentioned about prisoners, you know, folks who are in prison who are recovering addicts. And one of the drugs or treatment that I've been very interested in is Vivitrol. And I know there are pilot programs, I know here in Albany County and other parts of the state that certain sheriffs are doing it in their prisons, you know, for certain prisoners.

Is there any interest or any funding to assist localities, local sheriffs, with some kind of program like that? You know, one thing that interests me about Vivitrol is that it's not a narcotic, and there's not addictive qualities -- you know, no one's going to get addicted to Vivitrol, but unfortunately sometimes you can become addicted to methadone or another type of narcotic.

COMMISSIONER GONZÁLEZ-SÁNCHEZ: Right. Right. So we are providing funding. Currently I think we have 19 or 17 programs with local sheriffs throughout the state.

And we are providing funding for personnel to carry out these programs in the Vivitrol.

SENATOR ORTT: And how is that funding decided and then handed out?

COMMISSIONER GONZÁLEZ-SÁNCHEZ: How is it decided?

SENATOR ORTT: Like, where is it going, over the 19 counties?

COMMISSIONER GONZÁLEZ-SÁNCHEZ: Well, it's voluntary, so if there's a sheriff that says, I would like to implement this program, they speak to us. And we have a set amount of money that we have been funding all the other programs who want to keep it within that parameter, and yeah, we will support them if we're able to.

SENATOR ORTT: If you're able to as far as the parameters or the funding?

COMMISSIONER GONZÁLEZ-SÁNCHEZ: The funding.

SENATOR ORTT: Could I get a list of the 19 that are being funded right now?

COMMISSIONER GONZÁLEZ-SÁNCHEZ: Sure.

SENATOR ORTT: And where they are?

COMMISSIONER GONZÁLEZ-SÁNCHEZ: Sure. Sure.

SENATOR ORTT: And are you familiar with the proposal, the House of Hope proposal in Erie County?

COMMISSIONER GONZÁLEZ-SÁNCHEZ: Fairly, yes.

SENATOR ORTT: Okay. Are you fluent enough to speak to it, at least whether you think it's a worthwhile model to pursue or not?

COMMISSIONER GONZÁLEZ-SÁNCHEZ: I'm not at that point yet, no.

SENATOR ORTT: Okay. I would encourage you to take a second look at it.

You know it is supported, of course, by Avi Israel, whose Save the Michaels of the World obviously is -- he knows this topic probably as well as a lot of people who've spent their whole lives in it. But I think it's something that could be looked at as a potential model or pilot program or something the state could partner with to support, kind of like a self-direction on the OPWDD side.

This would be obviously on the --

COMMISSIONER GONZÁLEZ-SÁNCHEZ: Absolutely. Avi has been a great supporter. And yes, I am familiar but don't have the details. But I will be looking into it.

SENATOR ORTT: Please do. Thank you.

COMMISSIONER GONZÁLEZ-SÁNCHEZ: Okay. Thank you.

CHAIRWOMAN YOUNG: Thank you, Commissioner. We appreciate your testimony.

COMMISSIONER GONZÁLEZ-SÁNCHEZ: Thank you.

CHAIRWOMAN YOUNG: The next speaker is Jay Kiyonaga, executive deputy director, New York State Justice Center for the Protection of People with Special Needs.

Welcome.

EXEC. DEP. DIR. KIYONAGA: Thank you.

CHAIRWOMAN YOUNG: How did I do with the pronunciation of your name?

EXEC. DEP. DIR. KIYONAGA: I think you did better the first time. It's Kiyonaga.

CHAIRWOMAN YOUNG: Oh, I did? okay. Sorry about that.

EXEC. DEP. DIR. KIYONAGA: Jay is fine.

CHAIRWOMAN YOUNG: Okay.

EXEC. DEP. DIR. KIYONAGA: Good afternoon. My name is Jay Kiyonaga. I am the executive deputy director of the Justice Center for the Protection of People with Special Needs. I would like to thank you for the opportunity to testify today regarding Governor Cuomo's 2017-2018 Executive Budget proposal for the Justice Center.

Under the leadership of Governor Cuomo, and with the full support of the New York State Legislature, New York became the first state in the nation to create an independent state agency dedicated to safeguarding people with special needs. Before the Justice Center, there were no consistent definitions of abuse and neglect across the systems providing care to service recipients. There was no mandated reporting of abuse and neglect. Many systems lacked independent investigations of abuse and neglect, and police and district attorneys

did not have the dedicated resources to effectively investigate and prosecute these very challenging cases.

Today, approximately 1 million adults and children who receive services are now protected by the Justice Center. On June 30, 2013, the Justice Center began serving as the state's central reporting agency for incidents of abuse, neglect and other serious incidents. The Justice Center works closely with six state oversight agencies who are responsible for licensing, operating and certifying the services provided to these individuals.

Our primary responsibility is to ensure that people with special needs are protected from abuse, neglect and mistreatment. We recognize that the Justice Center may have created anxiety for some providers and staff members. However, it is important to remember that our investigations are triggered by someone calling the Justice Center to report that abuse and neglect may have occurred. We have a legal

obligation to investigate these reports, and we make our best efforts to minimize any disruption of services that may result from our investigations.

Our efforts over the past three and a half years have made facilities and programs safer for both individuals with special needs and the dedicated men and women who provide services. Still, abuse and neglect in these settings continues to be a serious problem.

In 2016, the Justice Center received reports of over 10,000 suspected cases of abuse and neglect. Most of these reports were made by staff members, service recipients, or their family members. Every one of these incidents is thoroughly investigated. Approximately one-third of all abuse and neglect cases result in a substantiated finding. In many cases, the Justice Center identifies areas of concern and works with State and provider agencies on corrective actions to prevent future abuse.

Now, people receiving services and their family members can take comfort in

knowing that employees who are found responsible for the most serious or repeated acts of abuse and neglect may no longer work with service recipients in settings under our jurisdiction. Since 2013, more than 300 staff members have been placed on a Staff Exclusion List. The workers on this list have committed offenses such as hitting, choking, punching and sexually abusing service recipients. Permanently removing these workers from the service system promotes a safer environment.

Workers who report abuse and neglect can now be certain that their reports will be taken seriously. Workers who are named as subjects of an allegation can have the confidence that a professional independent investigation will be conducted. They can also be confident that their legal and union rights will be honored, and that they can appeal any finding made against them.

The Governor's Executive Budget supports the Justice Center's comprehensive system for incident reporting,

investigations, employee discipline and prosecutions. With the support of state funds, the Justice Center has accomplished a number of goals since it began operations:

We conduct approximately 94,000 pre-employment checks each year to ensure new employees do not have a criminal history that would jeopardize the safety of people with special needs;

We ensure that mandated reporters and others can easily report allegations of abuse and neglect by maintaining a toll-free hotline, which is staffed 24 hours a day, 7 days a week;

We educate mandated reporters about their responsibilities;

We support high quality and timely investigations across the state through the operation of 15 regional offices;

We promote quality investigations by offering extensive training for investigators employed by the Justice Center, as well as investigators working for state and private providers;

We hold workers who engage in criminal conduct against vulnerable service recipients accountable. In 2016 alone, the Justice Center led 69 prosecutions. We also collaborate with local district attorneys by notifying them of alleged abuse and neglect occurring in their jurisdiction, and by providing assistance in prosecuting these cases;

We promote efforts to prevent abuse and neglect by collaborating with our Advisory Council and stakeholders. This has resulted in a model abuse prevention policy for providers, along with guidance on best practices to promote abuse-free environments for people with special needs.

In 2016 alone, the Justice Center's Individual and Family Support Unit provided support and information to over 3,500 individuals and families.

During our first three years, emphasis was necessarily placed on establishing an incident management call center, an investigations unit, and a prosecutor's

office. There will be continued attention given to process improvements in these areas, including efforts to complete quality investigations in less time by adopting administrative changes. For example, we are working to implement protocols to assess, within 72 hours, whether a report of alleged abuse and neglect should, based upon additional facts, warrant further investigation.

During 2017, a greater emphasis will also be given to other components of the agency and its mission. With the support of existing funds, such efforts will include a focus on abuse prevention and statewide outreach initiatives for workforce members.

With your continued support, we have been able to meet our mission of protecting the health, safety, and dignity of some of New York's most vulnerable people. The Justice Center looks forward to working with our partners in the Legislature, the state oversight agencies, and all of our other stakeholders to continue to strengthen

protections for people with special needs.

Thank you for the opportunity to provide testimony. I would be glad to answer any questions you may have.

CHAIRWOMAN YOUNG: Thank you, Jay.

How is the system different than it was prior to the Justice Center?

EXEC. DEP. DIR. KIYONAGA: I think the system is very different now, as opposed to before the Justice Center. First of all, there are standardized definitions of abuse and neglect across all the service delivery systems under the Justice Center's jurisdiction. There are strict mandated reporting requirements for custodians. We operate a 24/7 hotline to receive those reports of abuse and neglect. And we have investigators to investigate the -- to provide independent investigations of any alleged abuse and neglect in the system.

CHAIRWOMAN YOUNG: So thank you.

Specifically, are all individuals who engage in abuse or neglect identified, prosecuted, and banned from providing

services to people with special needs?

EXEC. DEP. DIR. KIYONAGA: Are all people who abuse people with special needs identified?

CHAIRWOMAN YOUNG: No, are -- well, are they -- those who engage in abuse or neglect, are they identified, prosecuted and banned from providing services to people with special needs?

EXEC. DEP. DIR. KIYONAGA: If someone reports abuse and neglect of a service recipient, it is fully investigated. And if it warrants criminal investigation or criminal prosecution, we would pursue that, either alone or with a local DA.

CHAIRWOMAN YOUNG: Conversely, has the triage process that the Justice Center uses experienced misclassifications of the appropriate actions that have resulted in incidents of abuse or neglect that should have been avoided?

EXEC. DEP. DIR. KIYONAGA: I think early on, there was misclassifications. We had a very short time frame to get our call

center up and running and staff trained and accustomed to the electronic case management system we had.

But we've worked very closely with the state oversight agencies to better define the types of activities that would fall into a reportable incident, whether it be abuse and neglect or a significant incident. And there are procedures for providers or state agencies to contact the Justice Center to review the information we receive to see if a reclassification is appropriate.

CHAIRWOMAN YOUNG: Staff who are being investigated as a result of a complaint may be placed on administrative leave or terminated, and the length of time for investigation forces providers to hire new staff, and employees then can be left in employment without pay until the situation is resolved. So this may lead to a significant amount of time.

The question is, what actions has the center taken in response to the numerous complaints regarding the length of time for

investigations?

EXEC. DEP. DIR. KIYONAGA: We've taken a number of actions since June 30, 2013, to try to ensure that we provide a quality investigation in a timely manner.

Some examples of that would be additional investigative staffing. We've added a lot more staff out in the regions. We've also instituted more regional offices to make sure that our investigators can arrive at the destination, a facility where they need to do the investigation, in a more efficient manner.

As I said in my testimony, we also have instituted a 72-hour protocol which we'll be rolling out broader over the new year. What that does is when we get certain reports of abuse and neglect, we -- before we launch an investigation, we work with the provider to gather more information to see if we can determine whether or not a reclassification is appropriate.

CHAIRWOMAN YOUNG: Thank you. So anything you can do to expedite the process I

think would be very beneficial.

There also have been numerous complaints that the Justice Center has a law enforcement approach for all investigations, regardless of the nature of the complaint. And this has led to fear and anger among provider staff.

How do you respond to these allegations, and what actions have been taken? Because obviously if it's a really serious, serious allegation versus something that may be minor -- I think that in the past, all of the allegations have been treated the same, and it's led in some cases to people feeling like there was an overreaction. So what have you done to change that?

EXEC. DEP. DIR. KIYONAGA: Clearly we take every allegation of abuse and neglect very seriously, as we should. I think that things have changed since before the Justice Center. I think that our investigations are more formal and more focused and independent. I think that's different than what the system

was used to before.

And I assume you're talking about, you know, private providers. But I can assure you that a very small percentage of the cases that are reported to us end up being a criminal case; about 1 percent lead to arrest or a prosecution. And so the other, you know, 10,000 or so are going to be handled on our administrative side.

And again, those would not involve our criminal administrators generally, they would be our administrative investigators. And on the private side, if the Justice Center is investigating, it's going to be a fairly serious allegation of abuse and neglect. We do delegate investigations back to providers to investigate. They all come back to us for review and final determination, but the lesser allegations of abuse and neglect on the private provider side are usually delegated back.

CHAIRWOMAN YOUNG: Okay, thank you.

CHAIRMAN FARRELL: Thank you.

Questions?

ASSEMBLYWOMAN GUNTHER: Yes.

Thank you very much for coming today. So I have a few questions, and I just want to understand like the proper reporting process.

ASSEMBLYMAN McDONALD: Aileen, hit the microphone.

ASSEMBLYWOMAN GUNTHER: Oh, sorry. We have to do sharing around here. Okay, thank you very much.

So first of all -- I just want to ask you just a few questions. First of all, how has the existence of the Justice Center improved the quality of care for vulnerable people?

EXEC. DEP. DIR. KIYONAGA: Well, with respect to abuse and neglect, clearly, for those victims, about 4,000 substantiated cases a year, I think that they feel that they would have justice as a result of Justice Center investigations and the creation of the Justice Center.

ASSEMBLYWOMAN GUNTHER: Well, before your existence, when you say 4,000, can you tell me about that? I mean, were they --

tell me the process before the Justice Center was created.

EXEC. DEP. DIR. KIYONAGA: Sure. I mean, each agency had different processes. The definitions for abuse and neglect varied across those different systems. And also the reporting requirements were very different across the systems.

So with the Justice Center, there was consistent definitions of abuse and neglect, there was consistent reporting requirements -- you know, specifically the mandated reporting requirement -- and then there's a call center to centrally receive all of those reports.

With respect to how we prevent abuse and neglect, I think I mentioned in my testimony that we do 96,000 pre-employment criminal background checks each year --

ASSEMBLYWOMAN GUNTHER: I'm going to interrupt you. Give me your definition of abuse and neglect. What is your -- like are there different categories? Like let me understand the definitions of Category 1,

Category 2, and Category 3.

EXEC. DEP. DIR. KIYONAGA: I mean, abuse and neglect is defined in the statute. There are four categories of abuse and neglect. So when -- abuse and neglect is a general definition. But once an abuse and neglect allegation is substantiated, our counsel's office assigns a category in accordance with the law.

Category 1 is going to be the most serious case of abuse and neglect, where there is usually serious injury. These things may even rise to a criminal level. Category 2 isn't as serious as Category 1, but there's a great risk of harm or serious injury. Category 3 is abuse and neglect but does not rise to the level of Category 2. And then Category 4 is more of a systemic issue. Category 4s are levied against a provider and reflect when there is either no individual culpability determined or there's a systemic problem that allowed that abuse and neglect to happen.

ASSEMBLYWOMAN GUNTHER: If you would

just allow me to -- you know, I have gone from place to place to kind of find out about the Justice Center and about non-for-profits. And, you know, before the Justice Center was created, a good non-for-profit had a quality improvement, and someone that already did some sort of research. And normally, I mean, if you ever got surveyed by a state agency, they were prepared for a survey and kind of knew. And of course there are things that are outliers and do go wrong.

So I'm just going to tell you what I've learned just from talking to different people. And I think it's -- I find this is something that we're going to improve the quality of care across the board, and that's why I'm here and that's why you're here.

So they said inconsistent categorizations, a lengthy wait of time for an investigation, re-delegation without notice. Lack of direct communication. Agency staff must still contact all relevant parties, but with significantly less information.

There's precious time needed to collect evidence; it's lost during this phase. So between Phase 1 and Phase 2, often people's image of what they saw or like, you know, three people might remember it just a little bit different if they're the witness.

They said the communication at the Justice Center is inconsistent. And I'm telling you this and going through this because I think that we definitely care about the developmentally disabled community, and we care about these investigations and we believe in quality of care. But we're also talking about very poor non-for-profits, people that are DSPs, and their feelings. And I think that, you know, we can only get better and this is, to me, a class in how can we improve the quality of care and the quality of work we're doing.

The timeliness of collection. The agency, in allegations of physical abuse, sexual abuse, suspends the target of the investigation. Which I guess you have to.

About the length of time of staff

suspension, they also talked about sometimes six to nine months. And after it's all said and done, they're found not guilty of whatever they were accused of, and it kind of goes on and on.

Just to give you an instance, the Justice Center has taken seven investigations at a certain place. And the inception was June 30th of 2013. Of the seven investigations, four are currently complete. If you're guilty or not guilty, only four are currently complete. And between the initiation and a closure letter, 153 days. So that's a long period of time.

So my question is, to you, after like me going out to the different agencies, what do you think you really did to really improve the quality of care? And also, what did we do to improve the quality of the workforce that are taking care of people with disabilities?

EXEC. DEP. DIR. KIYONAGA: Again, our mission is to protect people with special needs, fully investigate reports of alleged

abuse which are reported to us, in a timely and thorough manner. And again, I don't know the details, you know, which providers or which cases you're referring to there. I'd be more than willing to talk to you about that in greater detail separately.

But we are -- I think our interests are aligned. You know, I do want to make this system safer. We do want to make sure that people who shouldn't be working with people with special needs are not doing that in the future. And, you know, that's the mission of the Justice Center. We abide by the statutory requirements that were passed by the Legislature and signed by the Governor.

And again, there's a number of ways which I could explain that I think that the system is safer. I mean, quality of care -- I mean, abuse and neglect is only one part of quality of care, and I think you sort of went into the whole, you know, QA area there. But we have broad mandates there.

And again, prevention is something

that we're also very concerned about. I mean, I'm concerned that an investigation is very reactive. Right? Someone may have already been abused. And not that we shouldn't take it seriously, and not that we don't, but prevention is also something that's important. Which is why for every abuse and neglect case that is reported to us, we ensure that the provider and the state oversight agency do a review to see if there's any corrective action that's required.

And I think that sort of speaks to the QA piece you were just referring to. We want to make sure, if there's any compliance issues that need to be addressed -- and a lot of times that is like training or other things like that -- that the provider and the state oversight agency is working to implement those so people will be safer.

ASSEMBLYWOMAN GUNTHER: So statistically, how have you decreased the incidence, and what education have you provided? So sometimes we find things that

are really, absolute mistakes, they weren't done intentionally. What do you do to, like, retrain people? Or what is your -- do you bring a program into, you know, non-for-profits to tell them what to do and what your feelings are and what the corrective action should be?

EXEC. DEP. DIR. KIYONAGA: Well, I think every allegation of abuse and neglect, whether it's substantiated or not, is an opportunity for improvement. And that's why we require that providers and state agencies look at every case, regardless of whether it's unsubstantiated or not, to see if there isn't some corrective action that could make that facility safer.

ASSEMBLYWOMAN GUNTHER: Do you have a quality improvement or report that you could share with all of us so that we would see like the efficacy of the office and also like the changes, the improvements over the last three years?

EXEC. DEP. DIR. KIYONAGA: We issued our annual report recently, and that has some

statistics about the outcomes of our investigations.

It also talks about a number of the other things that the Justice Center does beyond abuse and neglect investigations, and that is, you know, we do forensics reviews, we do this corrective action plan monitoring. We have a prevention work group. So we do do a number of other things beyond our primary role, which is to investigate abuse and neglect.

ASSEMBLYWOMAN GUNTHER: Thank you.

CHAIRMAN FARRELL: Thank you.

Senator?

CHAIRWOMAN YOUNG: Thank you.

Senator Ortt.

SENATOR ORTT: Jay, earlier it was asked of you do you think it's --

CHAIRWOMAN YOUNG: Mic.

(Discussion off the record.)

SENATOR ORTT: Jay, earlier you were asked by Senator Young about are things different today than before the Justice Center. And you said yes, and you listed

some, I think, things that are important, but there are also things that -- there are things that we talk about here in Albany, you know, like that are, you know, the definitions of this and this. Not that that's not important, but I think on the ground level a lot of people don't see the difference. Or, if they see a difference, it's worse. Okay?

And what I mean by that is so, you know, when I talk to families, when I talk to providers, people on both sides of sort of the issue, on the one hand people will say, you know, the Justice Center, the investigations take so long. I think by your own testimony, you said most of the reports come in from staff. Two-thirds of them are unfounded. That seems to be a high number. And I say that in a variety of ways.

One, that's a large number of things that your folks are having to spend time on that turn out to be unfounded. And I guess my question would be, why do you think that is? What is your assessment on why

two-thirds are unfounded? Why are you having such a high number or volume called in that are unfounded?

EXEC. DEP. DIR. KIYONAGA: I mean, I can't explain it case by case. You know, I'd have to review those. But generally there's a few reasons why a case may be unsubstantiated. In our statute, it's substantiated or unsubstantiated.

You know, sometimes there are false reports that are made to us. We know that. It just didn't happen. That's what our 72-hour protocol is trying to get to. We do realize that sometimes things are misreported or falsely reported, and we think that through, you know, a quick review and some basic facts, maybe we can avoid the need for a lengthy investigation. Because you're right, you know, I don't want to investigate something that should never have been classified as abuse and neglect in the first place. Because, again, it is my resources or provider resources, and obviously it's a stress on the system that we would like to

avoid. So again, our 72-hour protocol is trying to get to that.

But the other reasons I think that things are unsubstantiated is maybe we just can't find enough evidence to substantiate that case. Our evidentiary standard is preponderance of the evidence, which is more likely than not to have happened. Sometimes we just can't get there.

So I think that those are really the two major reasons. Either something may have been misreported or overreported, and then in some cases our investigation just cannot achieve the evidentiary standard required to substantiate that allegation.

SENATOR ORTT: Let me ask you, so your folks have training, obviously -- a lot of them are law enforcement background or some type of investigative background --

EXEC. DEP. DIR. KIYONAGA: Twenty percent have a law enforcement background.

SENATOR ORTT: Okay. Do any of them have a background in the jobs that they're investigating -- you know, in human services,

working with folks that might have a developmental disability or something along those lines?

EXEC. DEP. DIR. KIYONAGA: Yeah. I mean, beyond the basic educational requirements and the investigative requirements, experience requirements, a lot of our investigators, many of them, have actually worked in the facilities which we oversee. A lot of them also have family members or loved ones who have disabilities as well.

I mean, that's what we're looking for. We really want investigators who understand the systems, understand our mission, and if they don't -- and most do -- we also provide training. And we also look to the state oversight agencies and providers to provide training to our folks too.

SENATOR ORTT: I think it would be helpful to see that grow, just because -- you know, I think one of the things that certainly would be a benefit, not only to you and your folks but also to the people that

we're trying to service, is if the folks who are doing the investigating had at least some understanding -- you know, real world understanding. Obviously, some of it's gleaned over -- I'm sure over years as they do this work. But if they come into it with some background in some of these areas -- because as you know, it's a very -- in ways, it's a very unique level of work and sort of what goes in and the individuals they're working with. So I think that's -- I would like to see that number or that percentage increased, not just education in a classroom, but real-world experience.

Do you know how many -- roughly how many people currently might be out on administrative leave as the result of a Justice Center investigation?

EXEC. DEP. DIR. KIYONAGA: I don't know.

SENATOR ORTT: Okay. Is there a way -- I mean, can you -- is that data available?

EXEC. DEP. DIR. KIYONAGA: We don't --

I don't -- I don't have access to that data.

SENATOR ORTT: You don't have access to that data?

EXEC. DEP. DIR. KIYONAGA: Yeah, we don't collect that data. Let me put it that way.

SENATOR ORTT: And I know a lot has been made about the amount of time that it takes to conduct these investigations. What would you -- I may have missed it. What would you say is an average time? Or what is, I guess, a time that you would like to see an investigation concluded?

I realize -- I mean, I know that you could give an answer that says, Well, every one is different. But, I mean, is there a certain time frame that you think is a reasonable amount of time to be able to make a determination to either close an investigation or prosecute?

EXEC. DEP. DIR. KIYONAGA: I would say our goal is to complete a thorough investigation as quickly as possible. I mean, that's what we owe -- we owe that to

all of our stakeholders. Whether it's the victims or the families or the provider or the subject of the investigation, a thorough investigation as quickly as possible.

But as you had said, there's a wide range of cases we get there. And, you know, I don't want to necessarily put a time frame on any individual case. I mean, again, if -- as I said earlier, if it's a false report and we can determine that very quickly, you know, someone is accused of doing something and they're not even at work that day, we should be able to close that very quickly. And I would hope that, you know, my staff or the agency staff would close that as quickly as possible.

On the other end, you know, some of these criminal cases can take a while. You know, they can take over a year in some cases. And so, again, we have a wide range. But we do have -- you know, we are working with the law of large averages here, right? We are talking about 10,000, 11,000 cases a year.

The statute speaks to, you know, a 60-day time frame; I think people are aware of that. Again, they say that we should strive to complete a case within 60 days. And if it's not completed in 60 days, we need to make a note of the reason in our database, in our case management system, and we do do that. But obviously since people are looking at 60 days, you know, I guess we would try to achieve things within 60 days.

SENATOR ORTT: How much assistance do you get from local DAs? I mean, how much cooperation do you get from local DAs in your investigations? Or how much do you seek?

EXEC. DEP. DIR. KIYONAGA: Well, I mean, we notify DAs of any allegation of abuse and neglect that occurs within their jurisdiction. They get those reports daily. We have multiple touch points, multiple collaborations with local DAs from there on.

Again, if we're investigating and we think that the case rises to a criminal level, our criminal investigators are prosecutors and will be working with local

law enforcement and/or that DA to vet that case. And again, if it's going to be a criminal prosecution, you know, we're going to collaborate and coordinate with that local DA to make sure that they're aware of the case.

And again, we would encourage local DAs to prosecute these cases. I mean, this is a crime that has happened in their jurisdiction, so first and foremost, you know, we would encourage them to do that. But if for whatever reason they aren't and we feel strongly about that, we'll work with them to allow us to prosecute it.

SENATOR ORTT: Does that happen a lot, where the local DA makes a determination not to and you feel strongly enough to move forward?

EXEC. DEP. DIR. KIYONAGA: I don't know if it happens a lot. I'm sure there's instances. I mean, when you look at our statistics, I think that in 2016 there were over 110 prosecutions, and I think we did a majority of those. But local DAs, they do

their share. I mean, I think we'd like to see them do more. I think we always think that if -- you know, given that it's a crime that occurred in their jurisdiction, it would encourage them to do that. But I recognize that they have resource issues, we have resource issues. These are very challenging cases. And, you know, sometimes they just don't see the inside of a courtroom.

SENATOR ORTT: Thank you.

CHAIRWOMAN YOUNG: Thank you.

CHAIRMAN FARRELL: Thank you.

Assemblyman McDonald.

ASSEMBLYMAN McDONALD: Hi, Jay, how are you?

EXEC. DEP. DIR. KIYONAGA: Fine.

ASSEMBLYMAN McDONALD: There we go, I think we're there now. Thank you.

And Jay, thank you.

CHAIRMAN FARRELL: (Inaudible.)

ASSEMBLYMAN McDONALD: I will. I will. Thank you, Mr. Chairman. I'll move up closer.

Thank you, as always. The Justice

Center has always made themselves available to at least the members locally, I imagine around the state as well.

And I have like a far-ranging comment before I get to probably what is a question. Sometimes I'm called with the whole -- the Justice Center, I think, has done some great things. It's established consistency in regards to instances, for the most part. It's established some good training, which I think is important. You know, and of course you're reaching across many vulnerable populations, but all different types of vulnerable populations.

So I understand the complication. And I also understand, as a healthcare professional, the importance of internal compliance within each organization. In other words, organizations do have to have their own policing of their own self to make sure that they have good protocols and operations.

And at the same token, we hear from individuals that we're not doing enough, that

more neglect is happening that we don't know about. And in that same token, it's not always easy to get good prima facie evidence of that.

I have a very large concern for the providers. Primarily it's the nonprofit community that I hear from. I don't hear much from the state agency organizations, I hear it mostly from the nonprofit community about a couple of different things.

First of all, you know, this approach that I think was prevalent early on but has kind of dissipated a little bit is this marshal-in-town-type mentality, which scares a lot of these $9.50 and $10 an hour employees. Now, I fully recognize that's not the Justice Center's issue of what people are being paid, but it's a symptom of a greater disease that we're not funding those entities properly from the state, because they're there to do the work the state can't do. But at the same token, we've descended upon them with this process which, when you say to a 21-year-old, You're guilty of obstruction of

justice, they're like petrified. And honestly, I don't know if that's very helpful in the process.

I was talking to -- and I think you talked to them today as well -- a local director who said that they had an incident, they did everything they were supposed to do, they forgot to notify the Justice Center because it was -- they did everything they were supposed to do, and now there's a fear they're going to be rung up for obstruction of justice. Which I'm sure it will be addressed and dealt with appropriately.

But I guess, you know, the largest concern I had, and I shared these conversations with Jeff when he was in the position before, is there just seems to be a whole lot of cases and calls being reported, and I don't know how, humanly, your individuals are able to do it. I know you've been working at it and working at it. But, you know, many of the organizations have made a suggestion, and I'd really like to get some thoughts from the Justice Center about some

changes that they think will have a positive impact -- not lessen the process, but really allow your folks, particularly your officers, to focus on what they should be doing. And it's to look at revising Category 3.

Those incidents are usually the lowest level of substantiation possible for an individual, and they're talking about allowing that to go back to the agencies -- obviously, in consult with the Justice Center -- which would allow you to focus more on the more serious cases of neglect.

So I'm curious to see, you know, what the position is of the center on that type of opportunity.

EXEC. DEP. DIR. KIYONAGA: Yeah, I mean you raised a lot of good issues there. Before I speak to the Cat 3 issue you just raised, I would like to just speak to, you know, our feelings about mandated reporters, you know, and the staff that do this good work.

I mean, we know that a vast majority of these workers are good workers. They do

this job, as you just said, not for the money but because they care about the people that they work with. And I think that's very important to recognize, and we do recognize that.

And of course that creates a tension for us. Because as you just said, you know, these people are afraid of us. But at the same time, the law requires that they report to us. If I don't get the reports, I don't hear about abuse and neglect, and I can't protect people with special needs.

So to that end -- and, I mean, we're in our -- we've been open about three and a half years now, and during the first couple of years we necessarily were focused on making sure that the state agencies, the executive directors of not-for-profits and private providers and their QA people knew exactly what was required under the statute and with implementation of the Justice Center.

Starting in 2016, and certainly continuing on to 2017, we have had a much

stronger focus on hearing directly from the direct support professionals. We have sort of aggressively worked with the National Alliance for the Direct Support Professionals, we've worked with all of the state oversight agencies to have direct meetings with direct support staff so we can hear their feedback directly. And I'll tell you, it's been eye-opening. And, you know, we hear it both ways, to be honest. Some are pleased we're here; some will say: "I'm so happy you're here. You know, I know that if I report abuse and neglect, there will be an independent investigation. I wasn't always sure that would have happened if I report internally in my agency." And we get that.

We've also heard that people are scared of us. We heard that, you know, "I don't know what to expect if I call your hotline." And so we've implemented things like putting a sample recording on our website, or playing it for direct support professionals.

We heard that our poster was

intimidating to people, that poster we originally put out. I don't know if you -- I think you probably saw it. It had a phone hanging, it was red, kind of scary. We've sort of shifted our view on that, and we've issued new posters which really show the collaboration that we expect from direct support professionals and the people they serve, the people with special needs we all want to support.

So I did want to address that concern, that we are aware of that and we are taking sort of aggressive initiatives to try to address some of those concerns where we can.

You also then raised -- I think which was really the point of your question, was the Category 3 and can we look at that. And again, I think Category 3 is broadly defined in the statute. But I think the real issue here is that, you know, we don't assign a category until something is substantiated and we're closing the case. Our protocols for assignment might sort of align with the concept you're talking about. Like I said,

you're mostly focused on the private providers. And for the private providers, the Justice Center only retains those cases which involve the most serious or egregious allegations of abuse and neglect. Those are going to be assaults with harm, they're going to be something sexual in nature, they're going to be some sort of potentially criminal -- criminal neglect, criminal action. Those are the ones we're keeping. The other ones we do delegate back to the state oversight agency and generally, from our experience, we simply delegate them back down to that private provider.

So I'd have to look at the numbers, and maybe we could talk separately. But I would guess that -- and, you know, we could probably pull this -- we could probably see, of the Cat 3s that are substantiated, how many of those were done with the Justice Center and how many were done by the privates.

But ultimately it may also turn out that something serious was alleged, you know,

we took that case on, and it turned out it wasn't quite as serious. But we could certainly look at that.

CHAIRMAN FARRELL: Thank you.

ASSEMBLYMAN McDONALD: Thank you.

CHAIRMAN FARRELL: Mr. Santabarbara.

ASSEMBLYMAN SANTABARBARA: Just to circle back, I know we touched on this before, but just in terms of improving the quality of care for a vulnerable population, how has the existence of the Justice Center accomplished -- how are you working to accomplish that goal?

EXEC. DEP. DIR. KIYONAGA: You know, quality of care is pretty broad. You know, our main mandate is really to protect people with special needs from abuse and neglect. And I think I can, you know, clearly point to the 340 people on our staff exclusion list. These are people who have committed the most serious and egregious acts of abuse against people with special needs. They were substantiated of Category 1, which is the most serious level of abuse and neglect.

They were put on the staff exclusion list that we maintain. They will be on the list for the rest of their lives, and they will be prohibited from ever working with people with special needs in any facility under our jurisdiction.

And so it's unfortunate that someone had to be abused to that level in order for us to identify and take action against these staff. But I think that, you know, for the victims of those cases, they would say that they would be safer now that this person is no longer able to work with anybody with special needs.

ASSEMBLYMAN SANTABARBARA: And can you speak to the experience, particularly in healthcare, that the Justice Center investigators have or need to have?

EXEC. DEP. DIR. KIYONAGA: The minimum requirements for our investigators are -- is an educational requirement, and then there's an investigatory experience requirement.

But as we interview, as we're seeking candidates, we are looking for people who

have experience in the facilities that we oversee. We find that that's invaluable. They really do need to understand not just the people with disabilities that they're going to be interacting with, they really need to understand the service delivery systems as much as they can as well.

And as someone had noted, we serve a broad number of different facilities. I mean, a developmental center is very different than a youth detention facility, which is very different from a group home or a dayhab. So it's hard to find someone who obviously -- you're not going to find anyone who sort of meets the mark on all those facilities, but we do find people who have worked in these agencies. A lot of our people have that experience.

And again, if they don't -- and again, they're probably not going to have experience across all the types of facilities they're going to encounter, or all the types of disabilities -- you know, we provide that training.

ASSEMBLYMAN SANTABARBARA: And my last question is, of course, you know, we're always looking to improve. What are some of the goals you see for the future? And do you have the resources to actually accomplish those goals?

EXEC. DEP. DIR. KIYONAGA: Yeah. I mean, our goals sort of remain consistent. And it's consistent with the goals that you guys have outlined.

We really want to try to make sure we continue to complete all investigations in a thorough manner in as little time as possible. So case cycle time, case completion time, that's something we're always going to be focusing on and monitoring. That's probably our number-one priority. That's what our stakeholders want. That's what you want, that's what the Governor's office wants, and that's what we're going to try to achieve.

Beyond that, I think that the direct support outreach is critical. I mean, we really do need to hear from our primary

stakeholder, which is the people who work with people with special needs. They are the people who must report to us, they are the people that we interview as witnesses, and they are the people that we may interview as a subject in an abuse/neglect investigation.

So hearing their input, making changes to our processes or our notifications, I think is critical and something we're going to continue to work on.

ASSEMBLYMAN SANTABARBARA: Okay, that's all I have. Thank you.

CHAIRWOMAN YOUNG: Thank you.

Senator Krueger.

SENATOR KRUEGER: I guess -- it's not a question, it's simply to point out you're hearing a lot of questions and I think the sense that people are concerned about your existence now. And I just want to go on record saying I hear both sides of it from people, and I think that reflects that you're doing exactly what you need to be doing.

These are tough issues. When people who are the most vulnerable in our society

are at risk of being harmed by the people we entrust their care to, it's our obligation as a civilized government to make sure that we are overseeing correctly, we are training correctly, we are fixing the problems.

And the numbers, as you were asked, show that there's a lot of unsubstantiated -- but people are going to have to do those kind of reports in order for you to figure out where the problems are and how you need to intervene. And that hopefully, within a matter of years, we're all going to be able to say New York State has the model programs for making sure that people who are under our care, whether it's in a government facility or in a community-based facility, are being treated with the highest respect and that the people who are hired to provide those services actually know and understand where the lines are.

So it's a very difficult job you and your people are doing. I'm sure you're not perfect at it. But I, for one, am very glad that you're out there doing that. So thank

you very much.

EXEC. DEP. DIR. KIYONAGA: Thank you, Senator.

CHAIRWOMAN YOUNG: Thank you.

That's it? Okay. Well, thank you for coming in today. We truly appreciate it and appreciate your input.

We have two groups who are appearing together, and that's Michael Seereiter, president and CEO of the New York State Rehabilitation Association, and Ann Hardiman, executive director of the New York State Association of Community and Residential Agencies. Thank you.

MS. HARDIMAN: Hi. Thank you. I'm Ann Hardiman, the executive director of NYSACRA. I'm going to turn it over to Michael first this time.

MR. SEEREITER: Hi, good evening. Thank you for the opportunity to testify.

Senator Ortt I think was quite prescient, maybe, in his comments earlier about what you are likely to hear from the rest of us after hearing from OPWDD and

others about the issue of workforce. That is what we are going to concentrate our comments on here today.

These are two organizations that are part of multiple campaigns that are focused on workforce issues, one being the Restore Opportunity Now campaign, and the other being the #bFair2DirectCare campaign. We are both very active in those campaigns because workforce has become the only issue, in many ways, that is important to us at this point.

The fields that we represent are in a crisis mode at this point. There's a recruitment and retention crisis the likes of which I think we've not really seen in the better part of several generations if not lifetimes.

The service expansions that we have seen in, for example, the OPWDD budget this year are appreciated. However, quite frankly, they mean very little if there is an inability, as currently exists right now, to recruit and retain qualified people to do this work. If we can't hire people to do

this work, we simply cannot expand supports and services.

Recently the #bFair2DirectCare campaign wrote a letter to the Governor requesting a meeting with him personally, in which we outlined three pieces of the crisis that we as a system face. The first piece really focused on the issue of the workforce and the workforce crisis.

We've seen, I think as several people have mentioned earlier, the vacancy rates for providers of services to people with disabilities have increased, the staff vacancy rate has increased 20 percent on a year-to-year basis, from 2014 to 2015. The use of overtime within these organizations has increased 13.5 percent from '14 to '15. And we've seen a 21 percent increase in the one-year turnover rate in staff.

Quite frankly, those are unsustainable numbers in any system, let alone those that are so dependent on public resources to be able to recruit and retain the qualified workforce they need.

The second piece of the crisis that we outlined was indeed a quality crisis. The issue that relates to this is that we are unable to hire qualified individuals and therefore cannot ultimately end up meeting the needs that are placed upon us as organizations that provide services to people with disabilities. Those can be even some of the most rudimentary health and safety quality issues.

And that then brings about a third crisis, which I think really is the one that we're starting to face across the system, which is a systemwide, indeed, crisis, where you have organizations that can no longer provide some of those health and safety bare-minimum requirements. I think that there's now a position in this system where the organizations that do provide services are no longer equipped to be able to take on new service capacity, as one organization may no longer be able to provide services.

That's a huge issue for the State of New York. The State of New York has the

statutory responsibilities to provide the services and supports to these populations, not the providers of these supports that contract with the state to do so. So as we see this budget taking place, the lack of the investment in the workforce is by far the number-one issue. Quite frankly, we can't see beyond that crisis to some of the other priorities that have been articulated in this budget or articulated by the administration, including the move toward managed care. Those become increasingly less clear as we are unable to meet the bare-bones minimum on a day-to-day basis.

We need to be able to create a living wage for people who do this work. We need to increase the value, the societal value of this work and thereby also increase the wage that is paid for this work. It is very difficult work, and we need that to take place in both fields that we're representing here.

In the developmental disabilities system, that's a $45 million investment that

we're looking for for a period of six years, over a -- each year, for a period of six years. And a similar investment in the mental health system of $50 million for six years. That's what's necessary to bring these jobs up to a living wage, something that, as several of you have noted earlier, does not require people to have two, two and a half, three jobs just to make ends meet.

CHAIRWOMAN YOUNG: Thank you.

MS. HARDIMAN: I'll be really quick.

I want you to know that direct support professionals wind up working more than one shift, oftentimes leading to weary, tired staff members delivering services. And their supervisors are now working shifts. And so good supervisors are really important for providing what DSPs need, and they're not there for them.

Three emblematic quick stories right now that represent what's happening on the ground. One, an executive director told me that he and his leadership staff get together every morning and decide what's going to be

covered today, where are we going to pull a staff person from to cover health and safety, what medical appointment needs to happen. The quality things that Michael talked about are not able to happen in many cases.

The second thing is another executive director telling me that the direct support professional people they are hiring right now, that are the pool to hire from, need as much mentoring and support as the people with disabilities that are living with them. And that's really striking and shocking.

And the third thing is an example I heard from one of my members. A person with a disability with very complex physical needs, sitting in a person-centered planning session with his circle of support, said -- and they're talking about what he wants for his life. And he said, "Well, you know, over the last year, 40 different DSPs have seen my private parts in the bathtub, and I want that to change. I want more staff that are regular, and not so many."

So -- he said something more graphic

than I did, but it's emblematic of what's going on. Yes, I won't go further.

So DSP work is complex and it requires skills that respect the dignity of people. And it's not a minimum-wage job. So we ask you, respectfully, to support including $45 million in the budget for a living wage.

Thank you very much.

CHAIRWOMAN YOUNG: Thank you.

ASSEMBLYMAN OAKS: Thank you.

CHAIRWOMAN YOUNG: I don't believe there's any questions, and I think you have a lot of people very sympathetic to your cause. So thank you.

MS. HARDIMAN: We understand. Thank you.

CHAIRWOMAN YOUNG: The next speaker is Steven Kroll, executive director of NYSARC.

Greetings. Thank you for being here.

MR. KROLL: Good afternoon, Senator. And good afternoon, everybody. Thank you so much for inviting us to speak today.

You have my written statement, and appended to my written statement is also the

testimony of the #bFair2DirectCare Coalition.

And Ann and Michael spoke a little bit about the workforce shortage. I'd like to just make two points today.

First, any one of us has an elderly neighbor or a couple or maybe a widow or widower that lives down the road or you can see from the house, that you've watched them age, struggle as they age. So you send your kids out to help them shovel the walk because they're so self-reliant they shovel the walk themselves. And then you see them carrying the groceries up the stoop and, you know, you go help them carry the groceries. And you watch them age and struggle to maintain their lifestyle.

Now, imagine if that couple or that individual was the caregiver to a developmentally disabled child and is not only struggling with their own life but struggling to support a child because they can't secure residential support for that child.

That's where we are today. We don't

have to imagine that. And there are thousands of them.

So all these parents are asking for is a residential placement so their child is loved, their child is safe, and the child is part of a community that will take care of them when they're gone. And we put them on a waiting list. And they sit on the waiting list for years.

They have no hope today unless they lose all capacity, such as have a stroke or they pass away, and then their child will be helped. And we have tons of excuses -- money, bureaucracy, just plain saying no.

So it's late in the day, and there are not a lot of people here watching the hearing, though some might be watching us on the web. But there's so many other things that we're doing right now, whether it be signs on the Thruway or waiving snowmobile fees or clearing the way for hemp farming and other important priorities for the state -- and we're leaving these parents out there and hanging. So I ask, is that the kind of

New York we live in?

So I was listening to the testimony of the executive deputy commissioner, and I was doing some number-crunching. So we're talking about 6300 new spots over three years. Well, about 1800 turn over every year. So if you take 1800 and you multiply it by three, we're talking about creating less than a thousand new slots over the next three years. So 300 or so slots a year for a waiting list that's 10,000.

So essentially we're saying to somebody who passes away that we'll find a home for your child after you pass away. And we've got some terrible, horrible tragedies, one I described for this committee last year that occurred right before the hearing, where a child's family had tried to find him a home -- the child was a 50-year-old man -- but tried to find him a home, and they found a home right after mom passed away.

And so is that our New York? Do we wait until people suffer tragedies, or do we try and find homes for their -- residential

supports for their children while they're still well so they can -- I always like to say, so they can go and visit their child in their new home every evening or every couple of evenings and tuck their child into bed, knowing their child is safe and secure and loved. Is that too much to ask for? Right now, in New York, it is.

So that's my first point.

My second point is to the DSP and workforce crisis. And Michael and Ann did a great job of describing, and you'll hear from some other speakers about that. I'll just direct you to a chart in my testimony. It's on the third page, it's a color chart. And this chart takes two agencies, and it shows in red their starting wage in 2006 and their starting wage 10 years later, the minimum wage in 2006 and the minimum wage 10 years later, and the fast food minimum wage.

So the top chart is a large agency in upstate New York. They paid 39 percent above minimum wage to their starting employees in 2006. Today they pay 3 percent above the

minimum wage, so essentially a minimum wage, and 7 percent below the fast food minimum wage, because the Fast Food Wage Board has moved the wage up faster than the Governor's transformation.

So it's very simple. We've been frozen for seven of the last eight years. The Governor has proposed to freeze us for eight out of nine. And so you can work 70 or 80 hours as a DSP to take care of your family. You may be on food stamps. You may give it up and say, You know what, there's a casino opening in Schenectady, I'm going to go apply for a job as a blackjack dealer. Or, You know what, it's a lot easier to run a cash register than it is to support people. I'd have to work on Christmas and on Thanksgiving.

The chart below is a large New York City agency. Same story. Sixty-three percent above the minimum wage in 2006, at minimum wage today, and 9 percent below the fast food minimum wage.

So every agency has a different story,

but these are two. We now have an average 11 percent vacancy rate in New York State. Michael talked to you about how that's continued to increase. There are agencies that are now well above 20 percent. Eleven percent is the average. And so Ann and Michael were not kidding, where every week or every morning the staff gets together and says, What are we going to get done today, and what's not going to happen?

And so people can become prisoners in their own homes. Because if there's not enough staff, they're not going to get out into the community. They're not going to be able to be involved in activities. And it's going to be like institutional care in their home. We're getting there, we're getting there quickly. That's why #bFair2DirectCare is together. And we are grateful that the Legislature and the Assemblymembers, the Senators, have all rallied to support. And we would love the Governor to put it in his 30-day amendments. I don't know whether that will happen or not. But if not, we just ask

that the Legislature, in the one-house budgets, put the money in to get us started towards a living wage for DSPs, and hopefully we can achieve that over the next several years.

So I thank the members of the committee for visiting with us today and especially for all of your support, and I'd be glad to answer any questions.

CHAIRWOMAN YOUNG: Thank you very much, Steve. Thank you.

ASSEMBLYWOMAN GUNTHER: Thank you.

ASSEMBLYMAN OAKS: Thank you very much.

CHAIRWOMAN YOUNG: Our next speaker is Glenn Liebman, CEO of the Mental Health Association in New York State.

Thank you for being here.

MR. LIEBMAN: Thank you, Senator.

Good evening, everybody.

CHAIRWOMAN YOUNG: Good evening.

MR. LIEBMAN: Thank you for the opportunity to testify at the hearing today.

My name is Glenn Liebman. I'm the CEO

of the Mental Health Association in New York State. We're comprised of 26 affiliates in 50 counties throughout the state. Our members provide community-based mental health services to over 100,000 New Yorkers with mental health challenges.

Our organization is also involved in advocacy, education, and training. Our core mission is to advocate for the greater good of the mental health community and to help eradicate the stigma of mental illness.

This is the 14th year I have had the opportunity to present testimony. Over these years, especially in more recent years, there's been great progress made in the fight to end the stigma of mental illness. Now, none of us are naive. We know we have a long way to go. But I really want to thank all of you for all you've done in recent years, especially our chairs, Assemblymember Gunther and Senator Ortt, because you've all listened, and you've acted.

In recent years there have been some real hard-earned successes for people with

mental health issues, through prevention, education, and public awareness efforts. This past year we had the passage, for the first time in the country, of a mental health education bill. And thank you for all your leadership on that.

There was great reference today to also the mental health tax checkoff, also landmark legislation, first in the country to actually talk about public awareness of mental illness on income tax forms.

So we're really moving the needle. And also what happened, which was a great victory, on New Year's Eve, we found out on New Year's Eve about the bill passing for step therapy. And thank you, Senator Young, for your sponsorship of that. That was really a great victory for all consumers across New York State.

So we're really pleased, and we really think that things are -- as frustrated as we all get, and I think we're all very frustrated, and I'll certainly share my frustration. But there is some really good

progress being made around a lot of mental-health-related issues, especially around public awareness.

Usually when I come and testify I usually do a slipshod approach, because we at the Mental Health Association, again, because we're involved in advocacy on so many different levels, we talk about a lot of different issues. We talk about veterans' issues, we talk about mental health first aid, we talk mental health education, we talk about -- you name it, we talk about it -- crisis intervention teams. We're always trying to talk about what we think is the most relevant issues around mental health care.

But like my predecessors, I want to talk specifically today about the cost of living adjustment and -- the COLA and the workforce issues, because they're so relevant to us.

As I referenced, this is my 14th year of presenting. And in all the years, I've never seen a greater need for a well-trained

and well-compensated workforce. I think of it -- you know, Steve did a great job of talking about it from a personalized perspective, but I also think about it from an agency perspective. You have to run an agency -- I know our MHAs across New York State do this -- with the expanding cost of healthcare and other ancillary costs of running a not-for-profit business.

You have to deal, in our case, with the transformation of the mental health system into a Medicaid managed care environment and the new expectations put on the workforce -- and I'll get into that in a minute, because it's not a bad -- there are some things in the transition that can be very positive. But again, it's all about the workforce.

Then you're dealing with the impact of the minimum wage, which we've heard about all day. A not-for-profit isn't McDonald's. We can't raise hamburger prices by a nickel to pay for the minimum wage. Without additional state funding, we would be unable to pay for

minimum wage increases.

According to work done by our colleague Doug Cooper -- who I know is speaking later -- from the Association for Community Living, as Michael Seereiter said, we estimate that there would be about a need of $50 million over six years to help pay the cost of minimum wage in mental health.

Our colleagues in the #bFair2DirectCare campaign have similar numbers on the developmental disabilities side. And just as an aside, they've done a great job of raising this issue, they really have. And, you know, credit to them for working so hard and being in every community in the state and talking about this issue.

But that's only one part of the story. The other part of the story is there's virtually no additional funding support from New York State. In mental health we've received only two COLAs in the last decade, and one was last year, at 0.2 percent -- 0.2 percent, which is akin to about a dollar a week for most employees.

This year again, sadly, the COLA is deferred. How many more years can a COLA be deferred before the workforce is completely decimated? At some point the logjam has to end. Our workforce can tell you, point blank, that things have never been more difficult in the nonprofit sector.

Now, we're part of a campaign called the Restore Opportunities Now campaign that's comprised of over 350 not-for-profit organizations across the state that call for crucial investments and systemic changes in New York's nonprofit services sector. The impact of the lack of funding for the nonprofit sector is seen across New York State, and they've done a wonderful report in terms of poverty numbers, individuals with disabilities, and food insecurity for both children and adults.

Many of the Governor's bold initiatives in the State of the State include things around expansion of indigent legal services, affordable housing programs, high-quality pre-K for 3- and 4-year-olds,

SNAP benefits, fighting food insecurity, mental health services for individuals who are homeless, et cetera, et cetera -- all important, and all things that are very significant and that we very much support.

But to work on these programs and to put these programs forward, you need the support and tireless efforts of the nonprofit sector to succeed. We must fund living wages that are competitive and keep pace with the increasing cost of living in the future.

Now again, from my own perspective at the mental health association, the issue is especially acute in the mental health sector. The workforce, like all the other workforces, are incredibly mission-driven. People know when they enter the mental health workforce it's not for the money, but it's for helping vulnerable people get better and move forward in their lives. Yet good feelings and mission-driven work does not pay the rent or student loans.

Again, we talked about Medicaid reform and the integration of health and mental

health. Who wouldn't want that? As a mental health advocate for many years, and as a family member, we would love to see the full integration of health and mental health. And that's what we're moving forward with, hopefully, in the Medicaid managed-care realm and around DSRIP and, you know, around value-based payments.

However, as progressive as the systems of care may be, you need a sophisticated and well-compensated and well-trained workforce to operationalize these changes. We must have a workforce enhancement if we are to continue to run quality programs and support for people with mental health issues to live in the community.

I'll just talk about three recommendations. The first one is fund the minimum wage increase through state contracts and Medicaid reimbursements.

The second is through the leadership of you in the Legislature, there was a COLA for the mental health workforce three years ago. That was very helpful. We need your

support to ensure that there is funding for another COLA for the mental health workforce.

And third, and there was -- Assemblywoman Gunther, we appreciate you asking this -- there was a discussion -- you know, you asked Commissioner Sullivan about workforce funding through the DSRIP waiver. This is an $8 billion waiver over a five-year period that has a specific set-aside of $1.08 billion for workforce and enhanced behavioral health services. Much of the money dedicated to behavioral health of the $1.08 billion has not been expended.

How is that money being utilized? And wouldn't there be an ability to redesign the waiver to ensure that the funding was going to go to the behavioral health -- not necessarily workforce, but behavioral health in general, rather than lose the funding from the waiver?

I think those are really important questions that have to be asked, because the specific language of the waiver says "This funding will support health home development

and investments in long-term care, workforce and enhanced behavioral health services."

Our colleagues at NYAPRS, the New York State Coalition of Children's Services, and the New York State Council for Community Behavioral Healthcare all support this important initiative.

And in final comments, we know that a very small percentage of the DSRIP dollars have been flowed to community providers. We want to make sure to incent the workforce by insuring DSRIP contracts with these providers for outcomes necessary to keep people out of the hospital and in the community.

The workforce is in desperate need of help and support, and utilizing the DSRIP waiver can help provide resources to the sector with no impact at all to the state budget and to middle-class taxpayers. We urge the Legislature to work with the Governor on this initiative.

And I could go on for another hour, but I'm sure you have a lot of work to do, a lot of people to hear from. So thank you

very much. Any questions?

CHAIRWOMAN YOUNG: Thank you, Glenn.

I think Assemblyman Oaks has a question.

ASSEMBLYMAN OAKS: Yes, Mr. McDonald.

CHAIRWOMAN YOUNG: Oh, I'm sorry.

ASSEMBLYMAN McDONALD: So, Glenn, thank you for your continued advocacy and work. Going back to the DSRIP, I'm assuming -- I just want to make sure of this -- that organizations like your own and local providers were invited to the participate in the PPSs. Is that correct?

MR. LIEBMAN: Correct, we are.

ASSEMBLYMAN McDONALD: As we know, the DSRIP is a very complicated process. You know, there's some that feel that it's primarily built for the hospital systems, for capital improvements, but it is really about transforming and moving towards a value-based payment system and value-based care.

MR. LIEBMAN: Correct.

ASSEMBLYMAN McDONALD: So are they not providing any nibbles? Or what will -- where

is the shortfall?

MR. LIEBMAN: Well, I think -- and there was just a hearing last week with the Department of Health and the five PPS teams across the state. And I think that the issue that they heard really consistently from -- I was one of them who testified -- from all 30 folks who testified, where the reality right now is that a lot of this money is not going to the downstream providers. So the PPSs are holding a lot of that money, and these downstream providers are getting frustrated by the fact money has not flowed to them.

We're three years in, almost; we only have two years left. We have to start really working into the movement to transition to value-based payment, and the only way we're going to be doing that successfully is if we have this funding and downstream providers can demonstrate their efficacy in this new world.

And I think, given the money -- and I know many of my members are frustrated -- given the money, I think that we could show

how efficacious we are as small non-for-profits in keeping people embedded in the community and not in the hospitals. So yes.

ASSEMBLYMAN McDONALD: For example, is it infrastructure? Technology? What is it that providers would be asking for? I mean, for those who haven't seen a DSRIP, the PPS plans, they are quite elaborate. They are very comprehensive. But the question is what is it, what is it that they need or what would -- to help them get --

MR. LIEBMAN: Well, I guess it's two questions. I've got two answers. One is the investment piece that I think the downstream providers, if they could get funding for their community intervention programs, the things they're doing with community supports in the program, whether it's peer programs, crisis programs, family engagement programs, those kinds -- supported education, supported employment. Those are the kinds of programs that keep people in recovery and moving forward in their lives. And I think that's

really important, that the downstream providers start getting some of that funding.

And the other piece, Assemblyman, is that we do have a workforce -- as we know, we've heard from everybody, and we'll hear for the rest of the night about the frustration of the workforce, how they're underfunded and undertrained and undercompensated, that there are DSRIP dollars out there -- not necessarily specifically dedicated for that need. And it's very hard, I get that, because you've got to go through a waiver, you have to go through the feds and all that -- but just to recognize how important that is to be able to maybe put some funding towards those downstream providers as part of PPSs, who would be part of the DSRIP network. It's just a -- it's an idea around specifically let's look at some of the funding here and figure out a way to work with the administration to -- you know, nobody is hiding anything, but just work with the administration to try to get this funding

moving forward.

ASSEMBLYMAN McDONALD: Thank you.

MR. LIEBMAN: Sure.

CHAIRWOMAN YOUNG: Thank you. Thank you so much for your testimony.

MR. LIEBMAN: Sure. Thank you.

CHAIRWOMAN YOUNG: Our next speaker is Harvey Rosenthal, executive director of the New York Association of Psychiatric Rehabilitation Services, Inc.

How are you?

MR. ROSENTHAL: Good, Senator.

CHAIRWOMAN YOUNG: That's good. Thank you for being here.

MR. ROSENTHAL: Well, thank you to the chairs and the members of the committees for the opportunity to submit the concerns of the thousands of New Yorkers that are represented by the New York Association of Psychiatric Rehabilitation Services.

NYAPRS is a very unique and nationally acclaimed partnership, very unusual in that we represent the needs and bring together folks with mental illnesses and the providers

who work with them across the state. And under this big tent we've been able to accomplish so much over the last, what, 36 years. We've brought recovery values to the center of our system, we've protected and expanded funding for community recovery focused services and our workforce, we've advanced peer support and human rights and fought prejudice and discrimination, we've expanded access to housing, employment and transportation, and we've helped win landmark criminal justice reforms.

State mental health policy is a very, very personal thing to me and our staff and a lot of our members because, as Mrs. Gunther knows, I have a mental illness and I tell her every day about that.

So we are in the midst of one of the most dynamic Medicaid and broader healthcare reform transformations in the nation. Over the past years we've integrated behavioral health benefits within Medicaid managed care plans. We have facilitated the creation of new local and regional health home and DSRIP

healthcare networks aimed at helping those with the most serious conditions to reduce their use of hospital and emergency services and to improve their health and their lives.

And we are moving rapidly towards a value-based environment where providers' efforts will either be rewarded or penalized for their ability to demonstrate measurable improvements in individual and community health.

New Yorkers with moderate to extensive behavioral health conditions have been a central focus of these reforms, especially because our community makes up an extremely large percentage of those who needlessly fill our hospitals and emergency rooms and our homeless shelters and correctional facilities and who die 25 years earlier than the general public.

Now, I've been proud to serve on many of the Medicaid redesign activities. I was on the Medicaid Redesign Team, I've served on the Behavioral Health Work Group, and I'm on the steering committee of the value-based

payment exercise. And I've done this because the state has clearly articulated values that promote wellness and recovery, prevention and diversion and an unprecedented commitment to addressing the social determinants of health and addressing poverty, hunger, homeless and social isolation.

Throughout, I believed that these reforms would be building on the unique and essential expertise and innovation of our community mental health and behavioral health systems that have decades of experience in knowing how to engage and serve individuals with the greatest needs.

Yet after years of hopeful and hard work, I come here today to say that our recovery sector and our workforce is as threatened as it's ever been, as you've heard today, even as our state reforms are failing, at the same time, to serve the very individuals that we understand the best and who trust us the most.

While billions of dollars are being invested in the transformation of our

Medicaid healthcare systems, a shameful trickle of dollars have been invested in helping our recovery sector to play the central role for which we were created.

While Medicaid redesign was intended to reduce reliance on costly hospitals, it's the hospitals themselves that are getting billions to oversee and to work to get people out of hospitals. It seems rather strange. And they're meant to oversee and offer care to groups that, all too often, they simply don't know and don't know how to help as well as we do.

In a landmark measure, Medicaid funding has been extended to pay for recovery services, the home and community-based services sector that Glenn talked about -- employment, education, and peer support -- yet only a handful of individuals have been able to access those services. And those services have reserved $645 million, and we have two years to spend it, and we're -- it looks -- at this moment, it really looks grim.

We've seen a succession of new funding streams to build organizational infrastructure, but our sector is only getting $100,000 or so per agency, while more traditional networks are getting tens of millions of dollars. Hospitals, if you go up to Albany Medical, if you go to any of these organizations, they've spent millions of dollars building -- you know, building buildings and hiring staff. But where the people are, and where the services are, that money is not going.

Simply put, our state is allowing our recovery sector to fail to keep up with the rapid pace of change and to retain a quality workforce on whom successful healthcare has always relied. In doing so, they are jeopardizing the survival of some of our most important programs and organizations.

Now, I'm not going to tell you that we need a COLA, because you've heard that with every speaker. And I won't have to tell you that we were denied a COLA again this year, and that denied us $9 million. We absolutely

join all the speakers here in saying that we must have a COLA, and we urge to work with the Governor to supply that.

We also join our friends at the Association for Community Living in seeking $50.5 million in OMH funding per year, for the next five years, to support the impact of the incremental increases to the minimum wage that were approved last session. In doing so, we can also address the impact of the changes to the New York State Department of Labor rules for exempt employees and overtime.

It's really important that we pay for the workforce. Our work is really about relationships. Our ability to engage folks and get them to trust us and make the changes that are necessary depends on those relationships. If staff are unable to stay in those jobs and those relationships, as good as they are, have to end, then we are betraying the folks that we're here to serve.

NYAPRS urges the state to set aside 25 percent of the $6 billion in DSRIP Medicaid

waiver dollars that, as I said, are currently going primarily to hospitals and hospital-led networks. Twenty-five percent is what we're asking for, while tens of millions of dollars are going to hospitals and not to the community sector.

As Glenn pointed out, there was a hearing last week and we learned, once again, it turns out to be 1 percent of all the money that's been put in this waiver is going to community-based organizations, only $12 million, while millions and millions of dollars -- I would say billions of dollars -- are going to the hospital networks. We must preserve the community recovery sector, and those monies need to flow there.

We have, as I said earlier, almost $600 million in waiver funds that are expressly dedicated to these kinds of services. And we only have two to three years left, and we're not spending it. We have a number of ideas to share with government about that, and we urge them to work with us.

NYAPRS joins our colleagues in urging that 25 percent of the proposed $500 million capital projects fund for construction, equipment and other nonbondable purposes be afforded the community and behavioral health, and actually the greater healthcare sector.

I live in Washington County, not far from Warren County, and I must say out loud that Glens Falls Hospital has received I think $5 million of capital infrastructure grants, and they're using them to build the kind of services that we already have in the community and ought to be expanded. They're building services instead of buying our services. That's unconscionable. We're eroding the service system we have while big institutions are rebuilding them, and they don't know how to run them. And that's why we're here.

On reinvestment, while we laud the Governor and OMH for the proposal to reinvest $11 million, there is $110 million in managed care savings. Very little of it is going to the community sector.

So we come to you for funds for a COLA, but there are funds in the budget, as Glenn pointed out, that won't cost the taxpayers and won't require you to find money that has to go into this sector.

In terms of housing, you'll hear more about that from our colleagues. But I'll cut to the chase. While there's $10 million to raise housing rates and fund 280 additional beds, we join ACL in seeking $28 million more to raise housing rates, recognizing that critically needed housing programs require $38 million a year for the next three years to remain sustainable.

We must take care of our housing programs. Our consumers rely on them.

Housing for the homeless. We know last year that the Governor and the Legislature were discussing and considering the Governor's plan to allocate $2.5 billion that would, in our world, build 6,000 new units of supportive housing. We got very little of that last year. We await a memorandum of understanding between the

Governor and the Legislature to fund these beds, and we urge you and your leadership to work with the Governor to do so.

I would say criminal justice reforms -- and I have to point out I'm here today talking to you in the Mental Health Committee, but a lot of what I'm talking about is really in the Health Committee and in the Corrections Committee, because that's where a whole lot of what we care about is housed.

And so I'm talking to you about it today hoping you'll go back to your colleagues and make changes in those areas. We need that so badly.

Criminal justice reform, we have champions here, Mrs. Gunther and Senator Ortt. You've been with us, in the last few years you've helped fund $3.4 million worth of crisis intervention teams. We can't thank you enough, but we will ask you for more for the coming year.

I will say, because I'm really trying to run through this here a little bit, crisis

intervention teams are critical because they keep people out of the system and they keep folks safe. So it's incredibly important that we train our police, and this program really works.

Perhaps the most compelling thing to me, after the workforce, is the torture in our prisons. We have thousands of people with mental illnesses who are sitting right now in solitary confinement, in a box, 23 hours a day in a box. We passed a law -- you passed a law some years ago, at our request, the SHU exclusion law, but still hundreds of folks, I think 900 individuals with severe mental illnesses, are in the box.

That's why we're joining again with our colleagues to urge your support for HALT legislation that's been sponsored by Assemblyman Aubry and Senator Perkins that will end the torture for so many. It will prohibit segregation of young and elderly people, people with physical or mental disabilities, pregnant women, new mothers, and LGBTQI individuals. It will end

long-term solitary confinement by placing a limit of 15 consecutive days and a limit of 20 total days in a 60-day period that a person will spend in the box.

It will enhance conditions in segregated confinement. It won't use the box, it will create these new residential rehab units, which are segregated, but will really be trauma-informed and rehabilitative in nature. So we urge you to look at that.

I'm out of time, aren't I?

CHAIRWOMAN YOUNG: You are.

MR. ROSENTHAL: So I will just end by saying we also would like to see the age of criminal liability raised from 16 to 18, and that there's money in the correctional system to fund the services that the kids need to be in the community.

Thank you very much, and I'm sorry I went over.

CHAIRWOMAN YOUNG: Thank you very much for participating.

SENATOR KRUEGER: Thank you.

ASSEMBLYWOMAN GUNTHER: Thank you,

Harvey.

CHAIRWOMAN YOUNG: Our next speaker is Wendy Burch, executive director, and Irene Turski, government affairs, National Alliance on Mental Illness, NAMI New York State.

Thank you for being here.

MS. BURCH: Thank you.

Good evening. My name is Wendy Burch, and as the executive director for the National Alliance on Mental Illness New York State, I represent thousands of New Yorkers living with mental illness and their families, whose hope of recovery hinges on many factors --

ASSEMBLYWOMAN GUNTHER: Would you pull your mic closer? I'm so sorry.

MS. BURCH: Is this better?

ASSEMBLYWOMAN GUNTHER: Yes, much better.

MS. BURCH: -- many factors, in particular a safe and affordable place to live, adequate services, and, when psychiatric emergencies do occur, first responders with crisis intervention training

and adequate inpatient facilities.

With me is Irene Turski, a family member of someone with serious mental illness, who has firsthand knowledge in dealing with our mental health system. Irene's family story is all too similar to that of many families who have a loved one with serious mental illness.

You have copies of our written testimony, so in interests of time I will be brief.

CHAIRWOMAN YOUNG: Thank you.

MS. BURCH: First I would like to thank Senator Ortt and Assemblywoman Gunther for their leadership, and I would like to acknowledge Senator Young for her championship of the step therapy reform bill recently signed into law.

Ensuring that people with a mental illness get the medication their doctors believe to be the most effective is a key component to recovery. Equally important is having prescriber prevails in place for those treating people through the Medicaid system.

Psychiatric medications are not interchangeable, and many living with serious mental illness having their healthcare met through Medicaid. We ask that the Legislature restore prescriber prevails to the final budget.

NAMI New York State operates a helpline for those seeking mental health resources. A significant amount of calls received deal with housing concerns. Housing availability is woefully inadequate to meet the needs of New Yorkers with serious mental illness. I urge you to heed the figures presented in our written testimony, and from our colleagues at the association for community living. Only with available housing with wraparound services, and continuity of care, can our loved ones hope for the chance of meaningful recovery -- and I know that's something everyone's been talking about today.

The other issue most often brought to light by our helpline callers is those with serious mental illness caught up in the

criminal justice system. We must continue to fund crisis intervention training for first responders. We must ensure that mental health courts are expanded so that the unique needs of those with mental illness can be addressed appropriately. We must raise the age of criminal responsibility, as detailed in the Executive Budget.

And finally, Assisted Outpatient Treatment, known in New York as Kendra's Law, has proven to reduce long-term hospitalizations, homelessness, incarcerations, harm to self, and dependency on drugs and alcohol. We urge the Legislature to continue to fund AOT and, in fact, pass legislation to make Kendra's Law permanent. Again, we acknowledge Senator Young's championship of this.

Everyone testifying this afternoon will tell you about the shortage of mental health services. Kendra's Law ensures that the ones who need services the most have first access to the limited services that do exist, including housing. And now I'd like

Irene to share a bit of her story.

MS. TURSKI: Thank you.

I speak to you today not solely in my role as government affairs chair, but as a family member and an unpaid advocate for those with serious mental illness. This is an advocacy role I did not choose. The decision was made for me upon witnessing the experience of my sister, who has schizophrenia. She has lived within the state hospital system and is now in a community residence program.

I assure you, the only reason she has been able to live in the community is because she resides in a program that incorporates the necessary support services to keep her healthy.

I have three concerns for those being transferred from inpatient beds into the community. Number one, people coming from inpatient psychiatric hospitals usually have serious mental illness and have lived for years under institutional control. Transition from a hospital to a residential

program is challenging. One of the many obstacles was ensuring my sister took her medication properly.

People such as my sister are not statistics or patients, they are human beings with complex needs who are not equipped to go into supported and supportive housing programs that do not offer the level of intensive care they would receive in a hospital setting. They must have the necessary support services, which are provided in a community residence type of housing, to teach them how and when to take medications and, in the most serious cases, basic needs such as personal hygiene and how to feed themselves.

On top of this, some of them are suicidal and a danger to themselves. Some suffer from anosognosia and do not know they are ill. Many who have been on antipsychotic medications may also be suffering from tardive dyskinesia, which causes involuntary movements of the tongue, lips, face, trunk and extremities. Tardive dyskinesia must be

addressed as early as possible, as the effects can be permanent and disabling.

Continuity of care for this population is essential. Only someone providing continual care would be able to notice the slight changes in a person which could indicate serious ailments. Continuity of care is only possible if providers can hire and retain qualified and caring staff members who build the types of relationships necessary to drive recovery. It is impossible to form these relationships if staff is constantly changing.

Number two. We have heard that housing providers received additional dollars for accepting people from inpatient beds for a two-year period. Since these individuals usually have serious mental illness, what happens after the two-year incentive? If this is true, is there any monitoring in place by OMH to ensure these people still have homes after the two-year period?

Number three. Despite the excellent care my sister received in her residential

program, she recently required a short inpatient stay in an OMH psychiatric hospital. While hospitalized, we found out that because her stay was OMH funded, she would lose her bed, her home, because it also was funded by OMH. Luckily, this was worked out, and she was able to return to the place she views as her home.

As anyone impacted by psychiatric disorders knows, the road to recovery is rarely straight, and hospital usage is sometimes needed. Those who need short-term hospital stays should not have to worry about losing their home. Hospitalizations can be traumatic by themselves, and this should not be compounded by the fear of not being able to return to the home you are comfortable in.

Being displaced can be a serious detriment to recovery. This is why I beg you to have OMH address this practice and introduce stipulations that a person's bed in a housing facility be held for them for an agreeable amount of time if they need short-term care in an OMH psychiatric

hospital. My sister and others, who have suffered a great deal throughout their lives, deserve nothing less.

Thank you.

CHAIRWOMAN YOUNG: Thank you very much. Thank you for your advocacy for Kendra's Law also.

MS. BURCH: We appreciate the opportunity.

ASSEMBLYMAN McDONALD: Thanks, Wendy.

ASSEMBLYWOMAN GUNTHER: We agree with you. That's right, we do.

CHAIRWOMAN YOUNG: The next speaker is Kelly Hansen, executive director of the New York State Conference of Local Mental Hygiene Directors.

Welcome.

MS. HANSEN: Good evening. Thank you, everyone, for hanging in there. Chairwoman Young, Senator Savino, Assemblymember Bob Oaks, and a former boss at one point in my career, Chairwoman Gunther.

CHAIRWOMAN YOUNG: What we're going to ask everybody to do is not to read everything

verbatim, in the interest of time, because I know people have been here a long time. We still have a lot of speakers to get through. So if you could summarize and --

MS. HANSEN: Understood.

CHAIRWOMAN YOUNG: Thank you.

MS. HANSEN: Thank you all for letting me come and give you our testimony today on the Governor's Executive Budget.

My name is Kelly Hansen. I'm the executive director of the Conference of Local Mental Hygiene Directors. The conference represents the county mental health commissioners. And the job of the county mental health commissioner is very different, and I'm going to be talking to you about things that you have not heard today, so there's something completely different.

But the responsibility of the DCS, county mental health commissioner, also referred to as the local governmental unit, is an oversight and planning and local role to ensure that the mental hygiene system, in watching all the moving parts -- to make sure

that there's services, they do the planning, the development and the oversight for individuals in the community, adults and kids, with mental illness, substance abuse disorder, and developmental disability.

One of the things I just want to stress is that the LGU is responsible for services for everyone, not just Medicaid.

As part of this, they're very embedded in the community. So the DCSs have linkages to inpatient providers, clinic providers, housing, shelters, DSS, law enforcement, criminal justice system, judges, family court, and the sheriffs. So it's from that view that I talk to you about a few things that are in the budget.

As you know, the other commissioners mentioned that we've moved to Medicaid managed care for the behavioral health population. Harvey referenced it before; we do have concerns about how that rollout is working, or very low numbers of individuals getting HCBS services. But the reason I bring it up today is because there's been

another cut to the funding that was put in place to help get the system ready. And the Executive says that this cut is for one year only, only because the children's Medicaid state plan services have not been approved and therefore would not be drawing down those funds.

What we would like to see is that that money is restored and invested in getting the system -- continue to get ready, especially on the children's side. There is a lot of work to be done. It's a complex transition. There's workforce development, there's infrastructure that needs to be put in place. And to us it doesn't make sense to cut that funding as an investment because the state plan services aren't up when it makes sense to get everybody ready so when the state plan services in the waiver are approved, they're ready to hit the ground running.

So we would ask the Legislature that you restore that cut in funding to the Behavioral Health Transformation Fund.

A couple of other things we want to

talk to you about today. You've heard from others that there is a proposal to look at all of the OMH state-operated clinics to see if they are viable, et cetera. It's a good idea. They are in a tough position.

From the oversight standpoint for the LGU, we're not opposing those closures or downsizing; what we want to make sure of is that that resource is funneled back into the community based on what the needs are in the community. We don't want duplicated services and we don't want unneeded services to help the state fit into specific positions that they need to be phasing out.

So again, we're asking for a collaboration with the LGU. We expect we will -- we have a good relationship with OMH that will continue, but we want to make sure the resource isn't lost and that it's used based on local need.

Same situation with the -- looking at the closures of the higher-end housing, the what are referred to as SOCRs and ROCRs. These are residential facilities that are

operated by the state. Many of them are located right on the state grounds of a psychiatric center.

This is a very high level of care, and it's still needed in the community. These facilities or residences serve people who have a repeated history of psychiatric hospitalization, criminal justice involvement, co-occurring substance use disorders, and homelessness.

In turning over those slots completely to supported housing with wraparound, we don't think that that will fit the need of what these facilities provide now. And they're state-operated; people can stay as long as they need the service. So from the county standpoint, we want to make sure for the system that that resource is not lost and that we still have access to that level of care in the community.

We also are supporting the $10 million in funding to increase the rates of reimbursement for the residential providers. Residential is a key component for the LGU.

The assisted outpatient treatment program is administered by the LGU. And as you know, those individuals on court-ordered AOT go to the front of the line in terms of being able to access housing and the highest level of case management, or now called Health Home Coordination. So it's critical to us that the housing providers are in place and staffed to be able to serve this population.

Moving to another piece that's in the budget, and this has to deal with the jail-based restoration project that would -- competency restoration, that would allow counties to voluntarily restore individuals to competency in the jail.

So let me just kind of explain how this works. So there's individuals who we refer to as 730s. That's 730 of the Criminal Procedure Law. And these are individuals who have committed a felony and have been found basically not competent to be able -- because of their mental illness or developmental disability. We get folks from OPWDD as well.

So there's two things. Because of

their disability, they are unable to understand the charges against them and aid in their own defense. What happens next is they are then transferred to the custody of the commissioner of the Office of Mental Health or the commissioner of OPWDD, and then they are moved to an inpatient forensic bed at a state psychiatric center or two of the developmental centers to be restored to competency --

ASSEMBLYWOMAN GUNTHER: That's like Mid-Hudson Psych Center?

MS. HANSEN: Yeah, it's Mid-Hudson, Kirby, Rochester and Central New York. And then for OPWDD it's Sunmount up in Franklin County and Valley Ridge in Chenango County.

So what the Executive has proposed -- and we've had many conversations with the Office of Mental Health on this, quite lively. And what the Executive has proposed is that these individuals could be restored to competency in a jail. And the argument is that the counties -- we pay 50 percent of the cost on a per-diem rate for competency

restorations.

The Executive would indicate that the counties are paying $40 million a year in competency restoration costs. This would save money.

We're taking cost completely off the table here. Our first concern, and why we're opposing, is that a jail is not a therapeutic setting to do competency restoration. The jails are not physically -- they don't have the physical plant that would be able to do this. They don't have the staffing, the clinical staffing -- psychiatric, psychology, social work, et cetera. They don't have the programming to do what would need to be done, four to six hours of programming, I think a week, for restoration.

And one of the other pieces is that in the jail, the jail does not and cannot go to court to medicate over objection. And we know that medication is one of the, you know, foundations of being able to help restore people to competency.

So -- but the other thing that you

absolutely need is the sheriff. This is a sheriff's department decision. It's not the decision of the mental health commissioner, it's the sheriff's department. They run their jails, they know their jails, they know who's in there, they know what they need to do.

So to our knowledge, and we've had extensive -- there's not a single sheriff in the state that is interested in pursuing jail-based competency restoration. But the budget books $2.2 million in annual savings.

So we think that's inaccurate. And what we would instead like to see is a more -- we'd like to see the Office of Mental Health take a leadership role in terms of bringing together those individuals that move along the 730 process. So it's obviously the sheriff, the district attorneys, the public defenders, the judiciary, the LGU and others.

Because it would do several things. It would help this wait time that we have for 730s. You know, the basis of this whole thing is my members tell me, my county

commissioners tell me, You can't get a 730 bed. You have to wait. And at any given time, there's 50 to 60 people waiting for a competency-restoration bed. And they're in our jails and, you know, with very high mental health needs. And we can't get these 730 beds. So --

ASSEMBLYWOMAN GUNTHER: Can I ask a question?

MS. HANSEN: Sure.

ASSEMBLYWOMAN GUNTHER: Are there many competency restoration beds that are available around New York State?

MS. HANSEN: I don't think there are any open beds for 730s, I think because there is a waiting list to be able to get a 730 bed for competency restoration.

ASSEMBLYWOMAN GUNTHER: Okay. Sorry.

MS. HANSEN: Anyway, moving on, so what we would do is ask for your support in urging the Executive to first of all not take a $2.2 million cut for a project that we don't see any savings or any benefit to, and instead be able to support a collaborative

process to help really, you know, get to more the root of this and be able to treat folks as we need to.

CHAIRWOMAN YOUNG: Okay. Thank you.

ASSEMBLYMAN OAKS: We have a question here.

CHAIRWOMAN YOUNG: Okay.

ASSEMBLYWOMAN GUNTHER: I just wanted to know about the competency restoration beds. Is that Mid-Hudson Psych Center? Is that a --

MS. HANSEN: Yes, there's beds at -- there's forensic beds -- and so that's the type of bed the individual is in. There's forensic beds at Mid-Hudson, Kirby in Orange County -- or Manhattan, I'm sorry. Mid-Hudson in Orange County, Kirby in Manhattan, Rochester Psychiatric, and Central New York Psychiatric.

ASSEMBLYWOMAN GUNTHER: I only know the one in my area.

MS. HANSEN: Mid-Hudson, yup.

ASSEMBLYWOMAN GUNTHER: Yeah. And if you were to ask me if that's a therapeutic

environment, I'd have to say "Wowzer."

MS. HANSEN: Well, what the Executive is proposing is that we do restorations in our jails instead of at a psychiatric center.

ASSEMBLYWOMAN GUNTHER: There's got to be something in the middle that's better than that. But that's my opinion, after going in and taking a tour. I mean, people do the best they can, but that place is a thousand -- I mean, I don't know how old that building is.

MS. HANSEN: I've never toured Mid-Hudson, so I don't have a reference on that. Toured many jails, but --

ASSEMBLYWOMAN GUNTHER: They're actually regulated by the Joint Commission, versus the Correctional. They're like considered a hospital, so they're not regulated -- they're regulated by --

MS. HANSEN: Not by the state Commission on Correction, it's JCAHO instead?

ASSEMBLYWOMAN GUNTHER: It's the Joint Commission. It's treated like a hospital, and they get a Joint Commission inspection.

So it's completely different.

MS. HANSEN: Understood.

All right, thank you.

CHAIRWOMAN YOUNG: Thank you so much, Ms. Hansen.

Our next speaker is John Coppola, executive director of Alcoholism and Substance Abuse Providers of New York State.

Again, we're going to ask that people stick within the deadline of speaking, because we have others waiting.

So welcome. Thank you for being here.

MR. COPPOLA: Good evening. I want to just start out by just sharing with you, as I was looking up at the panel here, I was feeling very grateful that each one of you has, I think, personally become dramatically more familiar with the substance use disorders issue over the course of the last couple of years. And based on your questions, it's clear to me that you understand the gravity of the issue.

I want to just recall that last year when I testified, I came expressing a concern

that we have a crisis and an epidemic, and I think this year I come with the same concern. And I want to point out, you know, over the weekend I was at a meeting in New York City with the New York Society of Addiction Medicine. And as the New York City Department of Health gave a report about opiate-related overdoses in New York City, the graph was -- the trajectory was in the wrong direction.

So in spite of all that we've done over the course of the last two years, we haven't done enough to stop the acceleration in the number of deaths and the amount of addiction associated with heroin and prescription opiates.

So the bottom line is we absolutely have to do more. There is nothing to suggest that the momentum is going to go in another direction.

I was alarmed -- I mean, I've worked in this field for many more years than I'd care to share at this point, but I was alarmed over the weekend when we started

looking at something like fentanyl and the degree to which fentanyl is now a part of many of the overdose deaths. And fentanyl is -- I think it's a hundred times the strength of morphine. So not that that's not bad enough, but carfentanil is starting to appear on the scene nationally: 10,000 times, 10,000 times the strength of morphine. And, you know, it defies the imagination to think what could -- this is a tranquilizer used for large game animals, right, that is now finding its way into the heroin that is being distributed across the country.

So this is alarming, and it's an indication that if things are not addressed, it will be a much more serious public health problem, and that's hard to imagine.

I want to just state that, you know, I personally have been to a number of wakes in the last year. Most recently, a 22-year-old young man, and before that, a 34-year-old young man, both of whom were very productive citizens and students at one point not too long ago, both of whom died from an opiate

overdose. And I think probably all of you know somebody in your district, or more than one somebody, who has been impacted by this issue. And I'm sure that that contributes to the urgency.

I want to suggest that the litmus test for are we doing what we need to do is the following. Is the magnitude of our response to this problem on par with the magnitude of the problem itself? So when the commissioner spoke to you about all the new initiatives that they're doing -- so whether it be peer navigators or these urgent care centers, when we look at them under a microscope -- and believe me, I think she is doing an incredible amount with extraordinarily limited resources. When you start talking about 10 new navigator programs, what exactly does that mean?

So how many hospitals are there in New York State? So we're going to now pick 10 of them and we're going to put two or three peer navigators in the emergency department to help people get into treatment instead of

being discharged into the street.

So again, that is not even remotely close to being something of the magnitude that is necessary. Right? So are we thinking about peer navigators in every single emergency department in the State of New York, yes or no? Right?

So again, it's not going to happen overnight, but 10 is not enough. And I think Assemblywoman Rosenthal's characterization that the funding is pitifully low is an accurate assessment. It is not possible to address this problem to the magnitude that's necessary if the conversation's context is a 2 percent budget cap. That is flat out not an acceptable context to have to have a conversation about a raging epidemic.

I'd like to suggest that, you know, when Assemblyman Cusick asked about the funds that we've invested, are they working, that's the right question. That's the right question, are we pointed in the right direction. Right?

The commissioner failed to brag a

little bit, I think, when asked a question about what's going on. She literally has established probably close to 10,000 new medication-assisted treatment slots across New York State that previously did not exist. That's a thousand people that are currently not on a waiting list. Right? So she's really to be commended for doing that, in addition to some of these other new projects. But again, the magnitude is the problem.

And Senator Krueger, when you were talking about the people that you're concerned about who are, you know, in the streets and not particularly interested in going into what probably are absolutely unacceptable living conditions in many of our shelters, right, I would suggest to you that we increasingly look to folks that are very knowledgeable about mental health and addiction services and ask the following question: Do they have any expertise that they could lend us as we contemplate what to do with homeless people who have got serious mental illness or serious addiction issues?

Do they have anything to contribute at all?

And I would submit to you that if you look at some of the housing programs in New York City over the course of the last five, six years, we're learning that a huge majority of folks who come into housing through a treatment program wind up in permanent housing, wind up with jobs, and wind up back in school.

So I would suggest to you that the -- if we look at how we're addressing many of these sort of tangential issues that result from people having serious addiction -- child abuse, neglect, domestic violence, various kinds of crime, et cetera -- and say is there something that the addiction treatment and mental health community can bring to bear on this issue, I would submit that there you might find resources and be able to move those resources from less effective programs into more effective programs, and that might be a good place to start.

But again, I think the whole question about magnitude -- it is not acceptable that

anybody that is willing to sit down with somebody and get into a treatment program, that it's not an acceptable answer that we don't have a bed, it's not an acceptable answer to say that there's a waiting list, it's just flat out not acceptable.

And again, I think when we get to addressing this issue to the magnitude that's required and necessary, you won't have that in any of your districts.

I want to just highlight a major issue that I think is really important, and that is, you know, as others have talked about, workforce.

It has been correctly pointed out to me that, in part, waiting lists exist not only because there are not enough beds, period, they also exist because there are empty beds that are not staffed. So programs are not able to recruit the staff necessary to guarantee patient safety and that somebody is actually going to get treatment. So there are empty beds in programs because they don't have the staff to

provide the treatment. That's not acceptable.

And it's a direct result of what some of my peers have talked about, which is, you know, as we're putting up these demonstration projects in hospitals and communities, one of the -- the vast majority of the programs across the state have not seen, you know, a penny to help support their staff. And so you adopt a new initiative with a new salary, and you're paying more than the people that are already working for you.

So we have to look at the workforce issue. And we're recommending, first, that we add staff for prevention in schools in New York City and schools across New York State as well as in the community. And we have a very specific recommendation that you'll see in the text.

Same thing for treatment, that we need additional staff. So this is about fundamentally what does it cost us to add one staff person to a treatment program upstate or downstate. Let's do the math, and let's

get the resources and let's do it.

And very similarly with recovery and the use of peers in our system. There's no infrastructure for it right now. In the mental health system you've got a state -- if you want to be a peer advocate in the mental health system, you get free training, free testing, free registration, free certification. You come into the OASAS system, none of that exists. If you want to become a recovery peer advocate, you pay for your training, you pay for your test, you pay to apply, you pay for everything. Right?

So again, I think that that's an important workforce thing. Which I think when Senator Akshar mentioned the asset forfeiture fund, I think if you do a little bit of homework, what you'll find is every single year there's a little nest egg sitting in that bank account while we're in the middle of a crisis. There is nothing that's more unacceptable than that, to have the money sitting in a substance abuse services fund that's not being utilized in this

environment.

So I would say, if -- and again, understood, we've heard it every single year, this is one-time money. You know, it's money that doesn't -- you know, we can't count on it for next year, so let's not use it for recurring costs because what if there's no asset forfeiture from one year to the next, we'll have a problem.

Okay, so let's use it for student loan forgiveness, let's use it for tuition assistance, training and support, scholarships, things like that for the workforce -- which, if the money isn't there, guess what, we don't have the expense.

If we can afford to do it, let's do it. So I think the investment in workforce is huge.

I want to just end by saying thank you. Were it not for the Senate, Senator Amedore and his leadership, Assemblywoman Rosenthal, Senator Young and Mr. Farrell, we would not have had the $25 million in the budget last year. And you are -- Senator

Young, when you were asking questions about this money, I think you were all on target. Because if you look at it for a second and say, What does this mean when the Governor says we're spending $200 million on the addiction crisis? The commissioner told you, well, how it gets calculated is we go to all of the people who are currently going through treatment, we ask ourselves the question, How many of those folks had an addiction to heroin, and we calculate what the cost of their treatment was.

A very different question is, How much new revenue have we invested in the treatment system as we have seen an increased demand for treatment because of this crisis? And the answer for last year was the $25 million that you put in there.

And for this year, it looks like there's an additional $25 million in the OASAS budget. Coincidentally, there's a $25 million increase in federal funds. So I do think that there is a lot more that we can be doing in the State of New York. And I do

want to end by saying thank you to all of you, thank you to OASAS, and thank you to the Governor as well for what has been done, but so much more is needed.

CHAIRWOMAN YOUNG: Thank you very much, Director Coppola.

ASSEMBLYMAN OAKS: Thank you.

CHAIRWOMAN YOUNG: All set. Okay, thank you.

SENATOR KRUEGER: The Assemblymember has a question.

ASSEMBLYMAN McDONALD: Can I ask one question, please?

CHAIRWOMAN YOUNG: Sure.

ASSEMBLYMAN McDONALD: Thank you.

What struck me was your -- when you mentioned the fact that there are empty beds because of staffing. Did I characterize that comment properly?

MR. COPPOLA: Mm-hmm.

ASSEMBLYMAN McDONALD: So I guess my question is, if I'm looking on the Combat Heroin site and I see empty beds, slots open, are some of those slots because of staffing?

MR. COPPOLA: Absolutely. I mean, and again, if you go to the site -- and, you know, they've done an incredible job of upgrading that site, because I think their first attempt was better than nothing, and right now it's much better than it was. But if you were to have a specific concept in mind -- I have an adolescent, 17 years old, and I live in Batavia and I'm looking for a residential treatment site, where is the closest bed for that particular person? Is it in Watertown, is it on Long Island, is it in Albany? I mean, where is the closest place to that?

So if you had -- for a woman who has a child or for a young adult, for a working person, et cetera, et cetera -- you know, once you sort of -- if you understand the different kinds of beds and you look at those beds, some of them are beds for people who are coming out of treatment or reentering the community. They're not appropriate for somebody who's seeking treatment or somebody who needs detox.

So when you say that today we have a thousand beds available, okay, great, that might be good. Let's drill down. Let's pick up the phone call, since there's a thousand beds, let's call all thousand numbers and see whether the person that I need to get into treatment can get into any one of them, and how many are real. I mean, how many of them, when I call the program, will they be able to admit anybody, much less the person that I had?

ASSEMBLYMAN McDONALD: It's a false positive, in some aspects. I don't think that's the intention of OASAS.

MR. COPPOLA: Of course.

ASSEMBLYMAN McDONALD: But the reality is -- part of the trauma is the parent is calling, trying to find someplace to put their Johnny or their Jessie, and, you know, they just don't know --

MR. COPPOLA: The tool that they do have online right now is dramatically better than it was, and they have the ability to continue to improve it. So I'm like really

optimistic that as people go to that site, they'll have a pretty good sense right away about whether a bed is available that would suit them.

ASSEMBLYMAN McDONALD: Thank you.

ASSEMBLYMAN OAKS: Thank you.

CHAIRWOMAN YOUNG: Thank you. Thank you for your advocacy.

Our next speakers are Edward Snow, PEF Regional 7 Coordinator, and Virginia Davey, council leader. Thank you for being here.

MS. DAVEY: Thank you for having us.

MR. SNOW: I guess I'm going to -- can you hear me all right? I guess I'm going to start.

Before I start, I just want to say thank you for taking the time tonight to listen to us, and I just want to say "Wow." So I know you've had a long day of listening to a lot of people and --

CHAIRWOMAN YOUNG: So if you could summarize, too, we'd --

MR. SNOW: Absolutely. I'm going to make it relatively short.

I represent the Labor Management Committee of OPWDD, which is the -- I'm the labor person who represents the union and coordinates all that.

The OPWDD budget talks about a $120 million investment into services in the coming year. The concern we have is that the services primarily are going to private-sector services, yet our concern is that in the past budget year, some of those same services were recommended to go to private agencies and they were unable to perform those services.

Specifically, the Long Island DDSO had -- there's the need to get away from the ICFs under the Olmstead Act, and they moved those -- the proposal was to move the Rainbow Commons people to a private provider, and that they would take over the services of those individuals. That never occurred, because they couldn't find a private provider that was -- had the adequacy to do it to take them on.

Now, in this year's budget there's

another proposal for another 100 people to leave the remaining ICFs at the Long Island DDSO and again be picked up by a private provider.

Realistically, it doesn't look like that's going to happen. They're still waiting for the first group to be placed, and now they've got a second group right behind it.

The other issue that they're proposing is that downstate, Long Island, that they want to start a START program, which is a crisis program to address crisis issues so that you don't have to have institutionalization and to aid people in the community. They started that program in the Hudson Valley, basically two years ago. It was fully funded last year, operated by state employees that were former members of the Taconic DDSO.

This year they're proposing that they want to do it again, through a private provider, on Long Island. We, as the public employees union, question whether they have

the ability to do, that can they find a private provider to do that. We, as state employees, have a history of doing that service, and we believe that that service should be allocated to state employees versus private-sector employees.

Our third concern is relative to a 56-person ICF reduction at the Sunmount DDSO. The proposal was for a five-year plan to have the population between the two forensic facilities, Valley Ridge and Sunmount, to 105 at the end of the fiscal year, March 31, 2017. The population at Valley Ridge is at 45, which is the proposal right along. The population at Sunmount, as of today, is about 160, I believe.

So they want to again propose that they're going to decrease the population at that site, yet you've heard today from many people issues about 730 beds. Those are primarily the beds at Valley Ridge and at Sunmount, the 730s. It does not look realistic that you're going to have that reduction in this fiscal year again, yet the

mode is that we push towards that.

The concern for the professional employees across the board is that when you're pushing for the privatization, you're pushing to get people out of these specialized beds, that you're often pushing so hard to get to your goal that you're kind of losing a little bit along the way. And our members are concerned when that happens, because sometimes people are pushed more than what they should be, and they're putting people and communities in jeopardy, when our members believe that maybe you should slow it down, that you should have a little better plan at times, and that doing that, you kind of safeguard the communities, you safeguard the people we're serving.

Our system certainly -- I've testified over the years, our system has really served some people well in the community. It's great for people to be able to move out of institutions, institutional living, and move into the community. That is the goal. The agency has attained that goal, and continues

to, but our concern is the speed and the process that's being involved to do that.

In my testimony there is a brief discussion about the Justice Center. I always kind of feel an obligation to have some discussion about the Justice Center. You heard a lot today about it. I was kind of happy to see the executive director of the Justice Center here, kind of giving his points of view.

One of the concerns we have with the Justice Center is the kind of frequent allegaters {sic} -- and the director kind of spoke about that today. But there really is not -- within a system where you have people in these specialized units, you oftentimes will have someone who will frequently allegate {sic} against a number of people.

I'll give an example that's in my testimony. Recently we had, at Sunmount, one of these frequent allegaters allegate that nine different staff people, who were women, had actually had a sexual encounter with him in the hall. Now, you know it's kind of

unlikely that that happened, yet the Justice Center took that call and processed that as a legitimate situation. The nine people were placed on restrictive duty, and that costs money.

And our concern is that at one time they had a talk of having a frequent allegater program. They used it once, and then, poof, it went away. So our concern is that that -- that the Justice Center still is in need of refining some of those issues.

So that's basically my testimony in a nutshell. I'm going to leave the OMH side to Virginia.

MS. DAVEY: And in the interest of attaining your goal of having this be short, believe me, the way I talk, reading it is going to work out better for us. So I'll read through it quickly, as quickly as I can, and then take any questions that you might have.

Good afternoon. Thank you for having us here today. My name is Virginia Davey, and I'm happy to have been selected by

President Wayne Spence to speak with you on behalf of the Public Employees Federation.

I mean the statewide labor management cochair of the OMH PEF Committee. Today I bring concerns, insight, and proposed recommendations from those who work on the front lines with the patients that we serve. I cannot help but find parallels between the hearing today and the daily charge of our members. As the Senate and Assembly leaders, you have taken on a huge task today, with several people bringing their concerns to you and hoping that you can say something or do something to help them to feel better. Based on the number of important people who have landed at your doorstep, I think you have experienced a bit of what our counselors face on a daily basis.

Like today, the number of patients at our doorstep is ever-increasing. One of the most pressing concerns identified in our OMH system is the task of serving an ever-increasing outpatient population without a corresponding increase in the budget

appropriations.

Although the shifting of employees from inpatient to outpatient care served to increase the numbers of counselors available for outpatient, that well is quickly running dry. The shift has not kept pace with community needs. This has resulted in caseloads that make it more and more difficult to provide quality care.

Exacerbating the recruitment and retention efforts in OMH has been the role of the Justice Center. Many are opting to work in different environments or worksites that are less likely to put their licenses and livelihood in jeopardy. Unfortunately, our system is not well in this capacity.

This fact makes it more and more unlikely that nurses who come to OMH will stay at OMH. Many OMH facilities are unable to meet their fill levels. Until the compensation packages can compete with private sector employees, we will continue to suffer the consequences of understaffing. More money has to be dedicated to getting OMH

online, because Commissioner Sullivan cannot correct this issue on her own.

Although PEF respects Commissioner Sullivan greatly, we still have some differences of opinion related to some of the proposed efforts to consolidate services and/or move services into the private sector. The gutting of OMH-provided inpatient services and the state workforce does not always settle well with PEF or the patients and communities that they serve.

I think by now you have all heard about the ongoing efforts to keep the Western New York Children's Psychiatric Center a stand-alone unit. OMH promised that these stakeholders would be given a seat at the table to determine the community need. These stakeholders and this community have spoken out loud and clear. At a time when we are trying to get buy-in from those with mental illnesses to avail themselves of much-needed services, we need to provide it on their terms, in their buildings, and in the locations that they choose.

We ask that you help them to keep their faith in OMH and the services they provide. We know this cannot be done without more money in the budget to offset the anticipated savings potential of combining the adult psychiatric center in Buffalo. The stakeholders are counting on us to find a way to put a moratorium on any efforts to upset a system of care that they have come to trust and rely on.

Likewise, we would ask that the effort to shift Hutchings Psychiatric Center services to Article 28 hospitals also involve all the stakeholders. If this endeavor moves ahead, it may be precedent-setting and be duplicated across the state. For this reason, we believe the Mental Health and Developmental Disabilities Committee and other supporters of healthcare should also weigh in on behalf of our patients.

Although Article 28 hospitals may provide good short-term care, longer-term care may need to be left to the OMH. PEF members are some of the staunchest advocates

for our patients, and we too need to be at the table during those deliberations.

With regard to the restoration-to-competency specialized units, PEF believes that the care of those who are in need of mental health treatment is best delivered in a nurturing environment outside the razor fences of a jail or a correctional facility. We would gladly accept the $890,000 to enhance services to not only those being restored to competency but to those who have served jail and prison terms and have been released into our communities. This would allow for a broader use of allocated funds.

PEF has brought issues to the table regarding concerns that our staff has not had proper training, resources and security unit designations to best serve this patient population. This solution could be a win for the community and the OMH patients at large.

Thank you for your time.

CHAIRWOMAN YOUNG: Thank you very much. I don't believe we have any questions. Thank you.

ASSEMBLYMAN OAKS: Thank you.

C0HAIRWOMAN YOUNG: Our next speaker is Paige Pierce, CEO of Families Together in New York State.

MS. PIERCE: Good evening.

CHAIRWOMAN YOUNG: Good evening. Thank you for being here.

MS. PIERCE: Thanks for sticking with us.

I think everybody up here knows me, but I'm Paige Pierce. I'm the CEO of Families Together in New York State. We represent families of kids with behavioral health needs across New York State. We're a family-run, family-governed organization, meaning that over two-thirds of our board of directors and most of our staff, including myself, are parents of children with behavioral health needs.

We have -- I've given my written testimony, which is really just a two-pager, so I don't need to read a ton. I'm just going to highlight a couple of the bullets for you.

One of the things that's most important to us is the notion that, you know, "Nothing about us, without us," that families have lived experience as peers that we can help share with other family members to help them navigate the multiple systems that our kids wind up in.

So when we have the kind of peer support that Families Together's members provide, we can help save money in many of the systems, particularly the mental health and substance abuse systems. Because the families who are entering those systems are at a loss, and the families who have navigated them in the past have a lot to offer.

And we have training and credentialing for those family peer advocates that can help all of our systems as they transform into Medicaid managed care and DSRIP and the like.

So I want to just make sure I hit on the important things. You know, families who have lived experience are experts in engagement. And you've heard over and over

again, with everything related to better healthcare, that engagement of the recipients is critical. We are experts on engagement, because we know what works. We have a level of trust and credibility because we're fellow family members, and we can engage families in a way that people with a lot of letters after their name can't.

I tell the story often about how we had a family peer advocate in a local county clinic, mental health clinic, and the family peer advocate was assigned to the parents when they came in, and they helped them navigate, helped them with everything from, you know, what do you need to make it to your next appointment, what kinds of barriers do you have to accessing services.

And the no-show rate in that clinic went way down once they had family peer advocates working with the parents. That's actual money. That's, you know, time at the county level, at the clinic, being saved.

And we would submit that those kinds of savings could be reinvested into more

community-based peer kinds of services that will help provide even more savings in the future.

Kelly Hansen talked a little bit about the state plan amendments that are part of the 1115 waiver that New York State is applying for with CMS. Until that happens, OMH still has money that they had put in the budget last year, and money for this year, that we're asking to please utilize this year. Don't wait for the federal government to give the thumbs up on our application for the 1115; it's not necessary. The money is there, and it should be utilized now to shore up our workforce, particularly our peer advocacy workforce.

The DSRIP. You've heard a lot about DSRIP today. When DSRIP first rolled out, we kept saying, as family and children's advocates, include us. Like I just said, we can save a lot of money on the end, on the bottom line. Because if you can provide the kinds of services that I just talked about, you won't need unnecessary hospitalizations

and ER visits.

They didn't spend a lot of time and energy on children and families because that's not their high users. It isn't a lot of young people entering the ER unnecessarily. But it is a lot of 21-year-olds, 22-year-olds, 23-year-olds. And the DSRIP programs had a five-year plan. So there are kids who are 17 now who, if they're provided the kinds of services they need, their numbers will be better five years from now.

So we would contend, spend the money early on, including on children's behavioral health and family peer support. And DSRIPs, insist that the PPSs utilize the existing workforce within the family peer services.

And then lastly, I just want to say that Families Together has our legislative luncheon a week from Tuesday, so it's on Valentine's Day, in the Convention Center. And we are recognizing Assemblywoman Gunther as the Legislator of the Year, and Senator Ortt. And you're all invited. You all have

gotten invitations. And we would love to see you there.

We have over 500 families who come from all of your districts, and they're here in Albany to meet with you, but also to hear from you what it is that's happening in Albany that's affecting their families. So I would encourage you to come.

CHAIRWOMAN YOUNG: Thank you very much. And thank you for your testimony.

ASSEMBLYMAN OAKS: Thank you.

MS. PIERCE: Thanks.

SENATOR KRUEGER: Thank you.

CHAIRWOMAN YOUNG: Our next speakers are Barbara Crosier, vice president for legislative affairs, and John Drexelius, Esq., legislative affairs, from the #beFair2Direct Care Coalition and the Coalition of Provider Associations.

Thank you for being here.

MS. CROSIER: Thank you.

MR. DREXELIUS: Thank you.

CHAIRWOMAN YOUNG: So again, if you could --

MS. CROSIER: We're going to be very brief.

CHAIRWOMAN YOUNG: -- summarize. because I just want to remind everybody, you have written testimony that's put into the record. So thank you again, and look forward to hearing what you have to say.

MS. CROSIER: Good evening, and thank you so much for staying. My name is Barbara Crosier. I am the vice president of government relations for Cerebral Palsy Associations of New York State, and I am here representing all nine associations on behalf of the #bFair2DirectCare campaign.

I think most if not all of you have joined us in various media events, press conferences, rallies, and have been very supportive of our ask. I think you're very familiar with the #bFair2DirectCare. We're asking for a $45 million investment over each of the next six years to be able to begin to start to pay a living wage for the hardworking New Yorkers who support people with developmental disabilities. In the

scheme of a $150 billion-plus budget, as Assemblywoman Gunther said, it's a spit in the ocean.

So you've heard about the vacancy and overtime rates, which are increasing at an alarming rate. Unlike state-operated facilities, where Helene talked about the fact that they're decreasing and they're able to hire, we are going in the absolute opposite direction, because we have not been able to give raises and our costs are increasing. House managers are working overnight shifts. So it's not only the loss of direct care workers, but as it moves up the chain and people are having to do overtime, the shifts are getting burnt out sort of at every level.

Assemblywoman Miller asked about self-direction. And I think a lot of the problem with self-direction is also being able to recruit and retain staff. So it really -- it is across all parts of our field.

And what we're asking for is less

than -- it's 0.0288 percent of the total budget. I mean, it's a minuscule amount. Attached to our testimony is an op-ed piece by Margaret Raustiala, who's a mom of a 47-year-old man on the autism spectrum from Long Island. I think many of you know Margaret. I would encourage you to read her op-ed piece.

And thank you on behalf of the more than half a million New Yorkers with developmental disabilities, their families, and those who serve and support them.

CHAIRWOMAN YOUNG: Thank you.

MR. DREXELIUS: Hi. I'm JR Drexelius. I'm the government relations counsel for the Developmental Disabilities Alliance of Western New York. And I'm here with Barbara tonight.

Winnie Schiff was going to give this testimony from the IAC, but she couldn't be here, so she apologizes for that.

We're here on behalf of the Coalition of Provider Associations, or COPA. COPA is a collaboration of five associations -- the

Alliance of Long Island Agencies, Cerebral Palsy Association of New York State, DDAWNY, the Interagency Council, IAC, and the New York Association of Emerging & Multicultural Providers -- because we really felt we needed to come together as a collaboration. We represent over 250 not-for-profit agencies across New York State. We provide supports and services to hundreds of thousands of New Yorkers with developmental disabilities, employ over 120,000 dedicated professionals, with a combined operating budget of nearly $5.2 billion.

Everything in my testimony has been said tonight. Senator Savino pointed out that -- how this administration can be saying that they've been giving us funding increases for the last four or five years when we're getting $134 million in state dollar cash less than we got in 2012. It's a Ponzi scheme. It's alternative truths. We have not. We have been starved, and we are now facing a real, real crisis.

Providers of supports and service for individuals with developmental disabilities are facing continuing rising costs, a population whose needs are growing in intensity, aging parents, and caregivers who need to do more for their loved ones with less.

I share everything that's been said tonight about the need for a living wage. And it's not the minimum wage; it's not enough. I'm preaching to the choir.

In terms of development, many of you up there have already talked about the fact that the, quote, unquote, $120 million which they every year roll out -- and every year it comes out of the hide of us, because it's a negative number at the end of the day -- is not enough. And it is not enough.

It also specifically doesn't -- it has very unrealistic expectations with regard to the number of individuals for whom low-cost services are appropriate. They don't recognize that there are significant populations that have higher needs -- the

sheltered work kind of programs that they do not want to fund. It's just mind-boggling that they're living in this alternate reality.

With respect to the OPWDD transformation, while healthcare is getting a $400 million pot to deal with the transformation, again, there's no new funding in this budget to support OPWDD's ongoing transformation agenda. The testimony I've got in here has many examples. I won't read them tonight.

With respect to the Justice Center and unfunded mandates and other system costs, all I can say is that we haven't received any increases for cost related to fuel, staffing, insurance, and we have not received the needed regulatory relief for the overwhelming paperwork and system-approved processes that are continually being added to this field.

We have expenses related to staff background checks, the OPWDD Front Door process and the Justice Center. They've all grown over time. No new money.

We recently -- COPA, working together with a number of other developmental disability associations, surveyed the field regarding the impact of the Justice Center. And the report, "Justice Center: Opportunity Missed," clearly articulates the detrimental effect that the Justice Center has had on the staff, supports, and the individuals who it was established to protect. And we would urge you to read that report and contact us with any questions and concerns.

And I've been up on that panel before, and I want to stop now because you want me to stop now.

CHAIRWOMAN YOUNG: Okay, thank you.

ASSEMBLYWOMAN GUNTHER: Any questions?

CHAIRWOMAN YOUNG: All set? Okay, thank you.

MR. DREXELIUS: Thanks.

SENATOR KRUEGER: Thank you.

CHAIRWOMAN YOUNG: Next is Christy Parque, CEO and president, Coalition for Behavioral Health.

MS. PARQUE: Good evening. I had

originally optimistically started my testimony with "good afternoon," but I'll say good evening.

And I want to say thank you so much for sticking around and your commitment to listening to us and partnering with us about trying to find solutions to help strengthen communities and strengthen the individuals in those communities.

I'd also like to say thank you. This is my inaugural testimony as the new CEO of the Coalition for Behavioral Health. I have testified before you all in the past, but not under this hat. So I'm very honored, and I do again appreciate you sticking around and the good questions that you've asked my esteemed colleagues who have testified before me.

So the Coalition for Behavioral Health is the umbrella advocacy and training organization for New York City's behavioral health community. We represent over 140 nonprofit community-based organizations, and we serve over 450,000 consumers with

services.

And what I want to say to you today is that I'm sitting at this seat with over 35,000 workers behind me in spirit. That's 35,000 full-time workers, we're probably well over 40,000 workers if you count the per diem and the part-time workers. And I don't take it lightly when I come here to testify on their behalf and the good work that they're doing. And the people who preceded me in their testimony from the developmental community also testified to the hard work of people that run their programs. And that's a lot of what I'm going to talk about, is the workforce and talk about the capacity and the infrastructure that we're facing.

So to understand a little bit more about who we are, we offer a whole range of services. Our members comprise an intricate network of safety providers throughout the neighborhoods they serve. And we care for the most vulnerable among us. It is critical that this network remain strong and intact, as the state stretches itself to achieve new

goals. And we support many of the goals and the directions that they're going in.

And we serve New York City communities in Long Island, Westchester, Rockland, Orange County. And now we have a strategic coordination for kids' work across the state, and we're very excited to take that on, because we realize we really need to speak with one voice for those 2 million kids that are on Medicaid in New York State.

The coalition's budget priorities really reflect the reality that we're facing as a sector. We strongly support the measures that preserve and strengthen community-based mental health and substance use programs through the reinvestment of resources in community-based services, the continuation of viable rates under Medicaid managed care, the preservation of a sustainable workforce, and the promotion of policies that prioritize consumers.

We are happy to see -- again, we support the idea that the state is moving in a holistic approach to serving the people

that we serve. So that means you'll hear terms like social determinants of health under DSRIP and Medicaid managed care. And we laud that effort, because we see our clients where they're at. We try to see them holistically.

So although I'm testifying before you today on substance use and mental health, my members also provide housing and emergency shelter, domestic violence services, and a whole host of other things, because they serve the clients where they're at when they come in, and we know that people have many facets to who they are. And so we want to be able to provide services within a network and within a safety net that sees them as a holistic entity and doesn't shunt them off to one area or a different area depending on whatever challenge they're facing.

I want to highlight just some of the specific budget asks that we have for the 2017-2018 state fiscal year as they relate to the recently released Executive Budget. You have my entire testimony, and you have a

one-pager that really summarizes well, I think, the concerns and the areas where we're grateful and the areas where we think that we could be doing a little bit better of a job.

So that the main areas that we're talking about, again, are infrastructure and capacity access and workforce. And the biggest ask on the top of that is a $125 million ask for the Healthcare Facility Transformation Program. The Executive's recommendation for that $500 million pot of money was they had set aside $30 million for community clinics. And that's only 6 percent of the funding. And it really fails to recognize the critical role of community-based organizations and the role they play in making and keeping people healthy.

In the past, hospital and larger healthcare systems have traditionally received the lion's share of investment funds under this and other state programs. The coalition is asking for your support for this $125 million set-aside for our community

clinics as part of this Healthcare Facility Transformation Program. We think it's going to be great for your community, it's going to be good for all the communities across the state.

So to that point, I just want to say we need a level playing field if we're going to be able to achieve the goals of managed care and DSRIP. And historically, the community clinics have been underresourced and overtapped for services. And so we think it's time now that as we're going towards valued-based payment and other models of coordinating across the state with hospitals and other community services, in order to really see our people and serve them with holistic services, we need to be prepared to be able to demonstrate the services that we're providing, that they have the intended effect.

However, we need the resources. It's the health information technology, it's the staffing, it's the physical infrastructure in some places if we're going towards

integration of physical and behavioral health services. And we have been, frankly, not given enough resources to get to where we need to be. It's unrealistic to think that we can achieve the outcomes that we can with the existing resources.

So we're grateful for the $30 million, we're grateful for the money we got last year. But what we're saying is we want 25 percent of that $500 million. We think it's fair, it's reflective of the statewide groups serving people in their communities with substance use and mental health services.

I do want to -- we're grateful to the Executive Budget for the extension of the APG rates until 2020. We had asked for that before the budget came out. We're grateful for that. We think that's really critical to help get us going towards a value-based payment system. That's going to give us time to work within our programs and bring them closer to where they need to be so that we really understand the impact that we're

having on the community.

And traditionally, as nonprofit providers, we've always come back, whenever there's been a cut or there's been changes to our budget, we say we'll be there, because we're the safety net. And now we are learning to value the work that we're doing, and we're really beginning to see how much the impact has been on our programs and how we have suffered under these cuts to be able to move forward quickly in business models.

And we're not just talking about this new paradigm of looking at people holistically about evidence-based practices; we've always embraced proven practices and things like that. We're talking about we have to evolve our business practices to quickly come up to speed under the next two and a half years under DSRIP.

I want to highlight in the package there's an article that we included that Politico wrote this week -- it's in your package. And recently it was disclosed that of the money that was made available so far

under DSRIP, which is about a billion dollars, the total amount that community-based organizations have received is $12.6 million. That's the amount of the money. So of the billion that's flowed, only 12 million has -- so it's about 1 percent has flowed to the communities.

So you see, again, an example of where community programs are being put to the side when it comes to resources they need to come up to speed and to support their programs.

So we encourage that there be more disclosure on how those funds -- and we encourage the Legislature and the executive branch to push the PPSs to release more of those funds back down to our communities.

I also want to note that in the Executive Budget we had -- we're happy to see $10 million to support the existing OMH residential housing programs. We think that's great. We want another $28 million. I know my colleague who will be testifying after me will be also bringing that up. We need to have about $35 million over the next

three years in order to bring our housing portfolio where it needs to be.

And what you need to understand about this housing, these are people that we've done the right thing by. They might have come through homelessness, they might have come out of prisons, state hospitals. And we've been able to work with them, stabilize them, build that confidence, and they have strong, stable lives in the community.

And what's at risk now is that as rents have gone up, the resources to the providers have gone down because of the value of the rents. So what happens is we have to creep into the cost of providing those services. And so it's really important that if we lose any scattered-site housing, it's very difficult to find more housing. So we don't want to break that social compact that we made with those folks about helping stabilize them in the community. And so we really encourage you to help us get that other $28 million.

Also I want to talk about the

workforce. And again, other folks have talked about this. We need immediate investments in the nonprofit sector. We need to invest in them in the short and the long term. We need to have COLAs.

The Executive Budget defers the COLA for one year. We would ask that that be reinstated. Because what is the message we're sending to the people who serve the most vulnerable? Many of our staff themselves are working poor. And what is the message we're sending to them when we defer even small COLAs down the road?

We also would like to have the contracts that we have with the state for human services across the state, not just for the O agencies. We're asking the indirect rate be moved up to 15 percent so that we can actually keep our programs running, including not just the operations but also the physical plants of what those look like, and allowing for things like training and other opportunities for our staff to grow.

We would like to see the Nonprofit

Infrastructure Capital Investment Program funded for another year, because last year only 40 percent of the 580 applications that were submitted were funded. So clearly there's a need.

CHAIRWOMAN YOUNG: Okay, could you wrap it up, please?

MS. PARQUE: Sure.

CHAIRWOMAN YOUNG: Thank you.

MS. PARQUE: And the last thing is related to the minimum wage for the O agencies. We are asking for $50.5 million per year for five years to support the impact of the incremental increases due to the minimum wage.

And my final point is that for children's behavioral health, we're asking for a $17.5 million investment, which is $7.5 million that was unspent last year to be reinvested for this year. And the Executive Budget shows a $10 million savings this year. This is not the time to save money on children's behavioral health. They've just moved into managed care. So we ask that we

have the $17.5 million investment.

And as far as the opioid epidemic, we heartily support that. My predecessor John Coppola did a fantastic job. We support everything he has to say. Listen to him, he's a wise man.

And we look forward for working with you more on that. You've done a -- the Senate and the Assembly has done a great job on that leadership.

And thank you for the opportunity to testify. You have my full testimony and our one-pager. And actually it's our lobby day today and tomorrow, so you've probably met or are meeting with many of my members.

So thank you.

CHAIRWOMAN YOUNG: Great. Thank you.

ASSEMBLYMAN OAKS: Thank you.

CHAIRWOMAN YOUNG: The next speaker is Lisa Wickens-Alteri, president of Save Our Western New York Children's Psychiatric Center Coalition.

Thank you for being here.

MS. WICKENS-ALTERI: Hello. Thank

you.

I just want to -- you have my testimony. And actually, I'm the president of Capital Health Consulting. It's actually a new firm in Albany. I am here representing the Save Our Western New York Children's Psychiatric Center.

We have been here before. In the beginning of the hearing this morning, you heard many members of the Western delegation ask questions and pose similar issues that we have raised in the past.

The advocates were really disappointed they couldn't be here. When the date got moved up, many of them have adult children or children they have to have services for, and they're in Western New York, so they couldn't make it.

I'm just going to give a few bullets and highlights to the testimony that we've already submitted.

The consolidation of Western New York Children's Psychiatric Center and Buffalo has been put off for the past two years. But as

you heard earlier today, OMH is already moving forward and the project bid is due back this month. Yet the state has yet to address the additional staffing and security measures that need to be put in place to try to prevent commingling between patient populations.

As the plan has been laid out, it is the children's treatment center placed on the adult campus. New York can do better.

Senator Gallivan pointed to moving young adults in adult prisons away from adults. Others have pointed out health projects that we continue to move forward on that focus on the care of the pediatrics, carving them out of the adult population so they receive the specialty services they deserve. They're not just little people.

We have increased the number of pediatric nursing homes, moving children away from adults. January 10th of this year, Albany Medical Center had their groundbreaking for a pediatric emergency department, and the CEO, James Barba, was

quoted as saying "It's just not possible to keep them completely isolated. This facility will not have adults in it. It will only be for kids, and that is very special."

Why are the children in Western New York any different?

Today we heard a litany of reasons why this consolidation just doesn't make sense, but we did not hear why it is completely necessary. This facility has the best outcomes in the state, and continues to have some. These children have lived and survived through abuse at the hands of adults. We have heard there will be more outpatient services to stem the flow of inpatient services, yet those services are inflexible to meet the needs of this special population.

The mobile integration team is a perfect example. Children are still ending up in the hospital, and then the children's psychiatric center. Last week there were seven admissions alone -- seven admissions in one week.

New York State has been committed to

identifying strong quality programs that will care for more people, more individuals, through the efficiencies that we've built, with strong quality outcomes. There are new innovative ideas being discussed and presented on a daily basis. I'm thankful I've actually worked with the Assembly and the Senate on the opiate epidemic we're having; we're doing a lot for children. We're doing pediatric ventilators in New York State, and we're opening new facilities and new programs.

But yet here we are, putting and moving more children to an adult psychiatric center.

The advocates have presented other options. Many of you have been supportive of them. The Western delegation has heard new options, new ideas, and the government and the state has really liked the ideas. They've asked us, yes, come back and talk to us -- but not here. Not for this site.

Western New York Children's Psychiatric Center currently services 19

counties. We implore the Legislature to push forward for other options. We're not just coming and saying "Don't move them to the adult facility" -- we've actually come up with other ideas.

And so let us make it work. Private/public partnerships. Other ways to put specialty services for children wrapped around this so that we can actually make some choices and give some other revenue streams to support the program. It's a great program.

So I ask that everyone comes to the table. Hold them accountable. We hear it's all moving forward, and every year you keep putting a stay on it, and yet here we are again. And this is it. We've got to make a move.

So I thank you for your time. God bless you for still being here. And have a good night.

CHAIRWOMAN YOUNG: Thank you very much. Thanks for all you do.

ASSEMBLYMAN OAKS: Thank you.

CHAIRWOMAN YOUNG: The next speakers are Arnold Ackerley, administrative director, and Clint Perrin, director of policy, Self-Advocacy Association of New York State.

Thank you for being here.

MR. ACKERLEY: Thank you for your time, everyone.

So I think it's important to begin to understand the nature of our organization, because what we've chosen to focus on is the #bFair2DirectCare Campaign. So we will be brief, as we know you've heard about this. But I do think it's important to understand why we feel it's important for our organization to speak.

There's something unique about our organization. The organization was actually founded by individuals with developmental disabilities, for individuals with developmental disabilities. And to this day, our board of directors is comprised entirely of individuals with developmental disabilities.

So as administrative director, I

report to them, and today have been asked to speak on their behalf with my colleague, Clint.

So I think it's very important to understand that when we talk about the issue of fair wages for direct support professionals, we're really talking about a direct benefit to individuals with disabilities as well. So a decision, you know, to fund those fair wages is really a designation to positively impact the quality of life of individuals with developmental disabilities.

I think we will find that quality of life for many individuals with developmental disabilities really begins and ends with the relationship and services that a direct support professional provides on their behalf each day.

I think it's also important to understand that the capacity of individuals with developmental disabilities to be contributing members of their communities and our economy is directly dependent on some of

those services. Without a direct support professional to assist them in many ways -- with transportation and some career counseling -- they may not be able to retain their positions, their jobs. They may not be able to even shop and, in some cases, may not be able to vote when it's time to do so.

And so I'll turn the floor over to Clint.

MR. PERRIN: Hello. Hello, all.

CHAIRWOMAN YOUNG: Hello.

MR. PERRIN: I speak to you today kind of uniquely. I'm probably one of the few people that you've heard from today who actually receives services. Yes, I'm a service recipient.

ASSEMBLYWOMAN GUNTHER: Can you hold that mic just a little bit closer? Thank you so much. Because I'd like to hear.

MR. PERRIN: I am a service recipient. And my direct support person is quite important to me. I don't think I would be here speaking to you today if she didn't work with me. And I certainly wouldn't -- my

apartment certainly wouldn't be as clean or as safe as it is.

That's all.

CHAIRWOMAN YOUNG: Okay. Well, thank you for being here.

MR. ACKERLEY: So would I be able to make one last point?

So I think one common experience we've heard through our board of directors when we reviewed this is that too many New Yorkers with developmental disabilities are really tired of seeing conscientious, good direct support professionals leave for higher-paid positions, when nearly a decade ago that was not the case. It was typically, you know, well above a minimum-wage position. So we just ask you to consider that.

We do understand that the minimum wage is being budgeted for. However, the profound responsibilities of the position and the importance of the position really merit a higher wage. And that's why we have joined with the #bFair2DirectCare Coalition.

Thank you for your time.

ASSEMBLYMAN McDONALD: Thank you. Thank you, Clint.

CHAIRWOMAN YOUNG: Thank you for participating.

ASSEMBLYWOMAN GUNTHER: Thank you for waiting so long.

CHAIRWOMAN YOUNG: Yes, absolutely.

The next speaker is Bill Gettman, CEO of Northern Rivers Family of Services.

ASSEMBLYMAN McDONALD: Not here. He's not here.

CHAIRWOMAN YOUNG: Oh, I guess he left.

Stephanie Campbell, director of policy for Friends of Recovery New York.

Welcome. Thank you for being here.

MS. CAMPBELL: Good evening. Thanks so much for being here. It's such a pleasure and an honor to sit here and talk to the folks that I actually used to work for.

So I am Stephanie Campbell. And as the director of policy for Friends of Recovery New York, I am honored to be here today and discuss how we can address the

public health crisis of addiction in New York State. And as many of you know, Friends of Recovery New York represents the voices of individuals and family members living in recovery from addiction, families who have lost a family member, and people who have otherwise been impacted by addiction.

The stigma and shame that surrounds addiction has prevented millions of individuals and families from seeking help, and we're dedicated to breaking down the barriers created by stigma that have resulted in discrimination and policies that block or interfere with recovery. And that's access to addiction treatment, healthcare, housing, education and employment.

But I'm also Stephanie Campbell, a person in long-term recovery. And what that means for me is that I have not had to use alcohol or drugs for over 16 years. Recovery has given me the opportunity to be a mother of two beautiful girls, one who is in her last year at Sarah Lawrence -- right now she's in Japan. I just got back yesterday,

so I'm a little jet-lagged; forgive me if I'm a little scrambled -- and a teenager in her junior year of high school.

Recovery has allowed me to be a partner, an employee, and a taxpayer instead of a tax drain. It's allowed me to save the State of New York millions of dollars because somebody made the investment in me and my recovery. And as a result, I went from being a homeless street kid in New York City to having a master's degree from Columbia University and an MSW from New York University. Instead of bouncing from jails to institutions, I now advocate on behalf of individuals and families impacted by addiction.

And it's really funny -- I want to pause here for a second -- I've had a number of you who I've worked with who, when I came out as a person in recovery, were shocked. Right? Because I look fairly, you know, normal. But the truth of the matter is that there was a time in my life when that wasn't my story, you know. And so to sit here now

and to advocate and to speak openly as a person in long-term recovery about the benefits of what happens when the investment is made -- I mean, when you think about, you know, the first year alone in my recovery, I must have saved the State of New York, I don't know, $500,000? I mean, when you think about, you know, cycling in and out of hospitals, emergency rooms.

So when we think about the investment I just want to be clear that it's not just the right thing to do morally and ethically, right, it's the smart thing to do financially. You know?

And so I'm not to go through all the statistics. I value your time. You guys know what's going on here in the State of New York. But I want to mention a couple of things that we are pretty clear on in our recommendations.

The first is that -- and I don't know how many of you have had the opportunity to read the Surgeon General's report, but he talks in Chapter 5 about the importance of

recovery support services, what he calls RSS. And, you know, I believe Senator Amedore had talked about the multipronged approach that we need to use, right, where we address this -- and it's not epidemic, by the way, now. It's a pandemic. There are more people dying from this disease than were lost at the height of the AIDS crisis in this country.

And I was in ACT-UP, by the way, and we were throwing ourselves in streets and carrying signs and doing all kinds of stuff because our people were dying because of shame and stigma and the lack of resources. We've now surpassed the 41,000 a year in this country that were dying from the AIDS crisis. We're now at 52,000 plus a year.

And you're going to hear momentarily from two people who were in the trenches -- one is Pete Volkmann, who heads up the PaRy program in Columbia County, and the other is Kristin Hoin, who some of you have seen, who's a mother who lost her child to this illness.

We must stop investing in the problem

of addiction and start investing in the solution, which is recovery. We support prevention and treatment for sure, but we have got to, when folks get out of treatment, have supports and services available in the form of recovery community organizations such as the ones that you'll hear about. We need to invest in recovery community outreach centers so that when folks come out, they can reintegrate and reenter their communities. We need to have family support navigators and peers. And you've heard a lot about that today. But we've got to have that. As John Coppola had said, and others, to have 10 programs in the State of New York is -- I don't even have the word for it. It's abysmal. It's completely unacceptable.

And so, you know, we're moving in the direction of really pushing that adequate resources -- and we're asking for $45.25 million this year, and that's a baseline. That's bare minimum. And that would cover, you know, recovery community outreach centers, RCOs, youth club houses, peer

advocates and recovery coaches and family support navigators.

But I'd like right now to turn your attention to Pete Volkmann, who's in the trenches as law enforcement, pulling people off the streets and getting them into recovery. So Pete?

CHIEF VOLKMANN: Thank you. My name is Peter Volkmann, and I'm a person in long-term recovery. My last drink was September 2, 1995.

As police chief of Chatham, New York, I made a conscious choice to stop arresting people who have an addiction and to get them help.

My part-time police department of 20 part-time officers, with a yearly budget for the whole police department of $157,000 a year, in seven months has placed 70 people into treatment, with insurance approval, within one day.

So I just did it to help people who I understood. And never expecting people from six different counties, as far as Utica, to

travel all the way to Chatham, New York, because their parents couldn't find a treatment bed. And we found a treatment bed for them. We are working well with treatment centers, and having an understanding of the dysfunctionality of both the insurance company approval process and the dysfunctionality of treatment centers. And the lack of treatment centers.

But the other piece that we found is many people relapse and still come back to us, and we find them a treatment center again. And that's where we've collaborated with Friends of Recovery New York because we need help. You could put someone in treatment all the time, but there's a lack of continuous care.

It's a recovery process. I wouldn't be here if it wasn't for the support systems that I was lucky to have in my process. And so as people are dying every day in New York State, I knew no other way, as a person on the streets as a first responder, than to start getting people into treatment. That's

the only way to save their life at this point. But we're missing that next process of trying to get people into the whole recovery life that I have been in.

So I was asked to come to speak about Chatham Cares 4 U and our program that a little part-time police department in Columbia County, New York, has placed 70 people in seven months with insurance approval. And the shortest time it took us was 15 minutes to have a bed with approval, and the longest time it took us was about 12 hours to find a bed. We have transported somebody from Columbia County to Utica. I'd rather pay my officers overtime in transportation than arresting somebody.

The other piece that is missing is we're partnering up and we're getting as much help as we can. Our officers are now volunteering their time because our budget is shot due to this. Our village mayor and village board is a hundred percent behind us. But we are limited, as a part-time police agency. And every person is a miracle. So

70 miracles occurred in a little village police department.

And so I'm here to advocate and to ask for you all to please help us, because too many people have died. It is beyond comprehension for our first responders and the mental anguish that we are all going through, and something just needs to be done. It is that bad on the streets. I will testify to that.

And so thank you.

CHAIRWOMAN YOUNG: Thank you.

MS. CAMPBELL: Thank you.

And now I'd like to introduce Kristin Hoin.

MS. HOIN: Hi, good evening. How are you? I'm Kristin, and I'm Summer's mom.

The last conversation that I had with my daughter was on January 9, 2015. We spoke about a sweater. And six days later, I buried her in that same sweater.

I struggle to remember if the last words that I said to her were "I love you," as they usually were. I then had the very

difficult conversation with her three children -- Ritchie, Caden and Anthony, 13, 4, and 3 -- letting them know their mother had died.

Let me take you back 12 years, a beautiful sunny afternoon, and I received a phone call: "Kristin, Summer is struggling with heroin." Way before the current heroin epidemic that we're in. The floor crashed out beneath me, and the hell that is addiction -- that somebody living in addiction, and their families, goes through -- became reality.

Summer went through a 12-year battle with this disease, and she fought to live her life in recovery for those 12 years. Part of that time was lived on the street, part of that time was prostituting, part of that time was in jail -- interspersed with times of recovery. She wanted to be sober. She wanted to live her life in recovery. I have handwritten journals and prayers begging, begging God for her life to be lived in recovery.

The irony is that Summer didn't die of a heroin overdose, like all of the reporters put in the paper because it's the story of the moment. The reality is that addiction has always been, and it will always be, long after this current heroin epidemic is over.

She won her battle with opiates. But like addiction, it was replaced with another drug and another drug and another drug. Periods of treatment, periods of life lived in recovery, interspersed with relapses, fighting her way to the top. Determined to live her life in recovery.

Why did Summer die that day? What happened? I truly believe that there were not sufficient recovery resources in New York State. Yes, it's difficult to get to treatment. Yes, it's difficult to get a bed. I can speak to 50 times that I took Summer to the ER and she was kicked out for just being an addict. To getting a treatment program, to being kicked out. But what happens is when she was successful, there was not a culture of recovery to come back to. There

were no resources here to have recovery community centers or family support navigators. She had the desire, she had the family support, but she didn't have the support of New York State.

I myself have created the Summer Smith 5K Addiction Awareness Memorial Run to stop the stigma that surrounds addiction, to honor those we have lost, and to celebrate those that are currently living their life in recovery. Last year we raised $21,000, and this year we are moving on and hopefully we'll be raising more money.

Summer was a student who graduated from Guilderland with amazing potential, but I buried her at 31 years of age.

But we can't do this alone. Individually, we're weak. Together as a group, a community, and a state, we're strong. We need our tax dollars to be directed to creating a culture of recovery where we don't attend and I don't have to speak at overdose awareness vigils or attend funerals or comfort moms who have lost their

children in Pineras {ph}, where I don't become the chapter leader of a grief recovery group called GRASP, for those who have lost somebody due to substance abuse. We need to be celebrating weddings and children's births and graduations instead.

And I would ask you, if it was your child, would you do anything less? Thank you.

CHAIRWOMAN YOUNG: Thank you. So sorry for your loss. Thank you for sharing. Thank you for all the good work you're doing.

ASSEMBLYMAN McDONALD: Thank you. Thank you, Chief.

SENATOR KRUEGER: Bravo, everyone. Thank you.

CHAIRWOMAN YOUNG: Our final speaker is Patrick Curran, steering committee member and cochair of the Eastern New York Developmental Disability Advocates.

Thank you for waiting.

MR. CURRAN: Thank you guys, very much. Thank you for being here, good evening, and for sticking it out. I

genuinely appreciate it, appreciate the opportunity. I'll respect your time and be as brief as possible.

And hello to Senator Krueger and Senator Young and Assemblywoman Gunther, my Assemblyman, Assemblyman McDonald. Thank you all so much, and the other people I've had the privilege of working with and knowing for a long time.

Tonight I'm here as the father of Katie Curran, a very beautiful 28-year-old young woman who was born with profound disabilities, during a period of time when I was working in these halls and doing much what you're doing right now.

But it's also my privilege to serve on the steering committee of two relatively recently founded groups, one regional here in the Capital District, Eastern New York Developmental Disability Advocates -- we call the acronym "Any Day" -- and the larger statewide group of which we are now a part, called SWAN, the StateWide Advocacy Network, which is a collection of, at this point, four

such groups from around the state -- DDAWNY, in Western New York, GROW, in Westchester County, FAIR NYC, and ENYDDA.

These are entirely independent parent and family all-volunteer organizations, and our sole purpose is to educate policymakers, the media, and the public on the issues affecting our children. Our only stake in this process is their well-being and their welfare.

Right now our best estimate, and it's a conservative one, is that our membership lists and mailing lists consist of thousands of similarly situated families. And we're very confident that we're representative of tens of thousands of more such families, which translates into hundreds of thousands of New Yorkers directly impacted by the issues we touch on.

You know, I'm not very well schooled in the Bible. I do remember that the last shall be first; that kind of sticks out right now. But following such powerful and effective testimony, as we've just heard --

and really what we've heard all afternoon I've been sitting here and kind of skimming my notes and flipping stuff out, saying, okay, they've heard all this in better ways than I can say it. So I'm going to skip over most of what we talked about. What I really wanted to do on behalf of our groups, which is what we try to do, is to put the personal face on all of this. Because we're just moms and dads and brothers and sisters. We don't have the resources and the numbers and data; we rely on providers and others for those. But we can speak to the reality of both dealing with the disabled day in and day out and what that means, even if you've got to do it at the end of a long night when you're conducting a legislative hearing that's run many hours late and you still have to go home and change the diapers and fix the braces and provide the medicines and do all those things. Because everything else just doesn't matter. That stuff still has to be done.

Then you translate that into the world of the direct caregivers, who have multiple

people at the same time, trying to do those same things, with almost an exponential increase in the complexities and the subtleties and the variations of the nutrition and the pharmacology and the orthopedics and the nursing care and everything else that goes along with that job. It's really quite extraordinary. But again, you've heard it expressed better than I can.

I think if our kids, if my daughter Katie could speak, I think she'd want to leave you with two concepts that stick out as we try to impact people with the importance of this: Toothpicks and continuity.

Toothpicks because if you take all the stuff that government does and that societally we do to help people like our children, all the programs, the school care, the respite, the residences, the whole nine yards, the billions of dollars, the bureaucracies, it's one great, grand edifice of stuff that really reflects our best impulses, what we're trying to do. And it's

all sitting on a foundation of toothpicks.

And those toothpicks are the direct care workers. Because every last service, every last thing that that constitutes, every last dollar that gets spent ultimately channels through their hands, physically, to these ultimate recipients, to our kids.

And if they're not there, or they can't do that job well, the whole edifice comes crashing down. And we're very close to that. I mean, it's crumbling now. It's getting very difficult.

And that kind of segues to the concept of the continuity, which you've heard expressed well and for a lot of reasons. I won't belabor it except I think to say that I don't think there's any other form of service from one human being to another in which continuity is as important as in providing service from a direct care worker to a disabled person. And not just for the mechanics. You know, most people, we talk about the mechanics of it all, or what I call the mechanics. The physical tending, the

medical care. You know, all that kind of -- all the things they have to do. And it's work. Trust me, it's a lot of work. Right? And it's life-sustaining.

But, you know, there's the other part that we all kind of aspire to. You know, you want to break through to these people that are trapped in these bodies without the ability to communicate, with intellectual and emotional capacities that we don't even know, because we can't get through to them and they can't express. And how long it takes to make those connections, to give us things we all need. You know, we all need that kind of personal connection and emotional contact and interaction. And it takes a long time to get that with somebody who's got these disabilities.

Similarly, or even sort of compoundingly, it's so much harder when you're the person with a disability, because your world is very small and you don't understand why these things are changing. You don't understand why the person who gave

you the bath yesterday, as I heard someone express earlier, isn't there today. Or why this was moved over here. Or why you can't get somebody to give you a drink of juice because they give you milk every morning because you can't tell them you want juice instead of milk. And so you throw a tantrum, and you're labeled as behavior-modified, and then you don't get to go to school.

All that stuff. It takes years to break through to that. But that's the continuity that is undermined by our inability, our collective inability to pay these people enough money to stay in these jobs for any length of time.

Now, I appreciate very much that -- I think -- you know, I see a lot of friends up here, and I know we're preaching to the choir. I mean, I get that entirely. So -- and we thank you for that. God knows we thank you for that. And we know we've got a critical mass of legislative support now.

But here's the deal. We all know how this building works. Okay? All this

support, it's wonderful. But it's not enough. You know that, we know that. What it takes is for you all to be able to go to your leaders and say, We know we've got a finite pot of resources and a finite number of asks that we have as legislators and as a conference and as an institution, and an infinite number of needs. And so we've got to make choices. Mr. Leader, we want this funded and we're willing to pay for it. We're willing to take this out of our pot and out of our hides. And we want you, in turn, to go to the Governor and say, Mr. Governor, the Senate, the Assembly, we need this funded or we don't have a budget. What are you going to do about it?

And we all know that nothing short of that is going to get this done. Despite all the talk we've had today, and all the support that I know is genuine, we all know that we've got to make that hard call or this isn't going to happen.

So that's what we're asking of you. We know it's a lot. We appreciate that.

We'll do everything we can, our tens of thousands of families around here, we'll do everything we can to support that and support you in that effort.

Thank you.

SENATOR KRUEGER: Thank you.

ASSEMBLYWOMAN GUNTHER: Thank you.

SENATOR KRUEGER: And thank you for being the last speaker.

ASSEMBLYWOMAN GUNTHER: Thank you for waiting so long.

MR. CURRAN: I appreciate that you guys are still here. It's great.

SENATOR KRUEGER: And this closes down our budget hearing on mental health and mental hygiene.

We have another hearing starting in this room, 9:30 tomorrow morning, but everybody should go home and come back.

(Whereupon, at 8:24 p.m., the budget hearing concluded.)