Coordinated Intake and Referral for Home Visiting Services

On November 18 and November 20, 2019, the DOHMH held listening sessions for Coordinated Intake and Referral for Home Visiting Services. In compliance with applicable laws and rules, attached please find transcripts from both listening sessions.

DOHMH is inviting comments to RFP@health.nyc.gov through December 26, 2019.
THE CITY OF NEW YORK
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CONCEPT INTAKE & REFERRAL FOR
MATERNAL AND INFANT/CHILD HEALTH HOME VISITING SERVICES

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MS. MOORE: Good afternoon everyone.

(No response.)

MS. MOORE: Come on, excitement, excitement.

My name is Erika Moore. I am the director of the Maternal and Child Health Unit at the New York City Department of Health. I am going to serve as moderator today for the listening session.

We have today Dr. Torian Easterling on the phone, the Deputy Commissioner at the Department of Health, that is going to give us some brief remarks, and then we will move forward into reviewing slides, as well as posing questions to the group to get some feedback on the Coordinated Intake and Referral Concept Paper, and soon to be, RFP. All right.

Dr. Easterling?

DR. EASTERLING: Yes. Well, hello everyone. Who is in the room? Are we
going to do an introduction, or is it just a listening session, and that can't be done?

MS. ASHTON: It's hard for people to identify themselves, we are in large room. I think it might be better for you to speak, then we'll send around a list for you to review afterwards.

DR. EASTERLING: Good afternoon, folks. Is that better now?

MS. MOORE: Yes.

DR. EASTERLING: Again, I am Dr. Torian Easterling. I apologize for not being able to participate in person. It would be so ideal if I was there in person, but unfortunately, I am just getting back to the office, and unable to participate in the Brooklyn office.

But I wanted to make sure, this being the first of the two listening sessions, that I share some remarks, as we are putting out this Concept
Paper in looking for a great partner for the Coordinated and Intake the Referral System.

It's important to say there has been a lot of tremendous work that has gone into thinking through the partnership, the system, both from a programmatic standpoint, a technological infrastructure standpoint, thinking about the impact that it will have in New York City.

So there's been a lot of thought, input and interest in trying to, really, figure out what infrastructure would be best to provide the types of services for mothers and infants, slash, children; making sure we are achieving clear, healthy outcomes for both mom and infant through this idea of achieving equity through birth, also reproductive health.

And so, you know, through the process we have been trying to engage our partners, to think about, you
know, through our home visiting
summits, think about some of the best
practices in all of the jurisdictions.

This has already have been
launched, you know, when you think
about what is happening in Baltimore
and New Jersey, and other parts of the
United States. So really thinking
about what will be an effective system
for New York City.

And so we want to go through this
process, and it's been quite a long
process, trying to come up with some
ideas and thinking about how this will
be funded, and how we will partner
with our community partners.

And so, you know, as you have a
chance to listen through what we are
looking to propose, how you can be
involved, and what the opportunities
will look like, we hope this will
bring some type of understanding of
what we want to achieve, and how we
can partner with our community
partners. So that is really what I wanted to just offer.

I think this will be a great opportunity for us to think critically about what we can achieve in all of the boroughs, and how we can make sure we are reaching the mothers and children who most need the critical services that we know are being offered by many of you who are in the room, and maybe some who are not in the room.

I know there are many organizations that are offering home visiting services, as well as much needed parenting services, as well throughout the community.

And so, you know, I thank you-all for being here and being a part of this conversation. So I will turn it back over to Erika.

MS. MOORE: Okay. Thank you, Dr. Easterling. Thank you very much.

As Dr. Easterling said, there is a
lot of work already, and conversations that have occurred around home visiting, as well as coordinating referrals.

This gives us an opportunity, or you an opportunity, to provide feedback to the Concept Paper that was released recently, as we work to finalize the request for proposal.

Okay. So your feedback is going to be critical as we work to finalize what the final RFP will look like.

So I apologize again for the technical difficulties. We were hoping to project this (displaying) on the larger screen, but we are having technical difficulties. So it will be up here.

We are making some copies to be shared, so we can all see. I will be going through a few slides and I will be reading them, basically, verbatim to make sure I get and convey the information correctly.
Then we'll have an opportunity where I will pose some questions for your feedback. Okay. Because we will be releasing the RPF, I will not be allowed to answer any specific questions.

But again, your feedback on the questions that will be posed is what is most critical for this process.

Okay.

MS. ASHTON: We are recording everything that is being said today. We have a stenographer who is writing everything down.

So as we ask the question, we ask that you please identify yourself and the organization, if there is one, speak loudly so our stenographer can accurately capture what the questions are.

Thank you.

MS. MOORE: I see that the slides are here and they will be coming around. Like I said, I will be
So the objective of the Concept Paper. The Department of Health and Mental Hygiene seeks to improve maternal and infant/child health and well-being outcomes by matching families' accessed risks to evidence-based or evidence-generating home visiting models through the use of a Coordinated Intake and Referral System.

DOHMH proposes to issue an RFP to procure services from qualified organizations to serve as borough-based operators for a Coordinated Intake and Referral System for maternal infant/child home visiting services in New York City.

So the overall goal is to ensure that New York City families have access to appropriate evidence-based or evidence-generating home visiting models by establishing a Coordinated Intake and Referral System that
incorporates a range of models from low to high intensity.

So the Coordinated Intake and Referral System will provide New York City families with a single point of entry for maternal and infant/child health home visiting services and other services as needed.

The families will be matched to the appropriate services based on their needs and preferences. The system will also efficiently manage the referral practice referral outcomes.

The Coordinated Intake and Referral System infrastructure includes technology for system operations and data management, risk assessment for families, in order to match them to the best home-visiting model that meets their needs; a system efficiency by centralizing the client family intake. Okay.

So that's end of the slide. This
information was taken from the Concept Paper. So now I will move into the question portion of the afternoon.

As Emily mentioned, we have a note taker here, so it is really important that we document whatever your feedback is to the question. I ask that you identify your name, and the name of your organization, we are documenting, you know, your responses and comments.

So as Dr. Easterling mentioned, we know that a tremendous amount of work has been conducted across the City to develop the regional Coordinated Intake and Referral System. Our goal is to learn from these existing programs and to build upon the work to date.

Based on lessons learned what successes should be incorporated into a citywide effort; and what does not work? So we have a few questions. Right?
So Sylima (phonetic) will be keeping time for us, so we can get through all of the questions.

This is the first question, who is up first to give a response? Who is going to break the ice? What successes should be incorporated in a citywide effort? What does not work?

All right.

MS. WEST: I am Denise West with the Brooklyn Perinatal Network.

I believe, at least in the Borough of Brooklyn, because -- let me ask a question before I answer the question. Is it going to be one per borough, one system per borough?

MS. MOORE: Can we answer a specific questions. So one per borough, that is what is projected, funding, depending on funding.

MS. WEST: I would suggest to look at what is being done at the building. Like, in Brooklyn, we have the Brooklyn Family Connect. Looking at
what is working in the referral process so that you are not reinventing the wheel.

Central intake is not new, it is something we did back in the '90s -- doing that. So looking at what is currently happening, and building off of what is currently happening.

I believe one of the lessons that should be incorporated is not -- building off what was already started so that you are not starting from scratch. I know, at least in Queens, there's something happening; Brooklyn there is something happening; I would assume Manhattan as well.

MS. MOORE: Are there particular specific successes that you could identify?

MS. CADET: Hello. I am Brandi Cadet with the CAMBA program.

So I think each of the coordinated intakes in each borough is in a different place. So in Brooklyn we
just started, I want to say, less than nine months ago. So we are still very new.

Queens, I think is in a much different space. So I imagine borough by borough there may be different successes and challenges.

MS. MOORE: Okay.

MS. ROSA: Hi. Marci Rosa with Public Health Solutions.

To answer the question here, I think what you want to make sure of is part of this, in addition to just the evidence-based visiting program, would be -- that is what I'm thinking the question that was asked; is that correct?

MS. MOORE: We know there is work that has been done, as it relates to the Coordinated Intake and Referral System, right, throughout the city.

So are there particular successes, challenges or lessons learned from those particular -- that particular
process that we should be aware of?

MS. ROSA: I still want to answer the question on the page. I want to make sure that Doula services were part of the coordinated intake, as well as parenting groups, and other services for families that are not going to qualify for one of the home visiting programs.

In terms of successes, there are some around the city and the state, there are many more across the country; I know that you have all of that information. But we've been doing this work in Queens through our Healthy Start program for almost five years.

We've been pretty successful, but there is always room to grow, and there is always room for funding.

MR. MOORE: Okay. So is there anything that has not worked that we should be discussing?

MS. CADET: What has not been
successful is not tying any funding in
the coordinating intake efforts.

MS. WEST: Denise West.

The other thing is deciding on,
like, an IT system that can be used.
Everybody, they use whatever their
grant gets, that can be used for three
or four different systems.

So ensuring we have one system
that is -- it may already be out
there, I am not going to say too much
to disqualify ourselves, but a system
that people can use that can address
the different programs.

What is not necessarily successful
is trying to just address one thing
when agencies are providing a variety
of different services. There's
different funding, it's not broader or
coordinated with the other services
they are providing, it is not
necessarily user-friendly for the
organization.

MS. MOORE: So they are providing
other services, other than home visiting you're saying?

   MS. WEST: Yes.

   MS. BREWSTER: Paula Brewster with Queens Healthy Start.

   One thing that I think is important with any coordinated intake, is also to find outreach. What has been successful in our coordinated intake is also having an outreach coordinator in addition to --

   MS. ROSA: One person --

   MS. BREWSTER: But, you know, outreach and coordinated intake go hand-in-hand. So if you have an outreach person or team, in addition to your coordinated intake, it makes everything for the mother more feasible.

   MS. MAGGIE: Maggie from SCO Family Services.

   I would also like to add that clearly outreach is really important. Again, some programs have funded
outreach efforts, and some don't. I would also say on the other side of that, all of the referral sources also have varying degrees of resources themselves.

So unless there is some thinking about how you are going to really help bolster all possible referral sources in efforts like this, you end up with referrals coming from places that have the most, you know, resources, or the staff have been there a long time, they don't turn over in the same way.

So that's been our experience for over ten years, that really has a huge role in clients being referred or not being referred.

MS. CADET: What has been a challenge -- one of the challenges has also been either a lack of clarity or different policies around who is the point person in hospitals or medical institutions.

Um, from one hospital to the next,
you would have to kind of understand the landscape of that institution before you develop your outreach strategy.

I think it will be great to have, as part of this effort, some pathway system that ties in directly, either to the city hospitals, or a larger boroughwide hospital system so that if there is an outreach person identified, they don't have to reinvent the wheel, depending on which institution they go to.

MS. MOORE: So I will take one more question and then we will move on. There will be another opportunity, I will share with you on the slide a place where you can send additional comments.

MS. BREWSTER: Paulette with Queens Healthy Start.

What is really important, as with any hospital system, is administration so that it is embedded in the culture,
in terms of the outreach referral system; then also find your champion in the hospital.

So it has to be done in a way that filters into their current system so that it doesn't become another task, that they are referred to the coordinated intake -- yes.

MS. MOORE: Thank you.

The next question. The Concept Paper describes the contractor's role in general as partnering with community-based organizations that currently deliver home visiting services.

Working closely with the DOHMH, Community Advisory Committee, social service agencies, and community-based organizations to guide development, and implementation of the Coordinated Intake and Referral System and provide ongoing input.

Conducting data entry and management for the entire process,
from receipt of the referral to the
home-visiting program assignment and
communication back to referral source,
if authorized.

Is there anything else that would
be important for the development and
implementation of the Coordinated
Intake and Referral System.

MS. ROSA:  Marci Rosa, Public
Health Solutions.

I think that it's important for
there to be structure set up where all
of the boroughs are talking to each
other in a systemic way. Because the
way people get their health care in
New York City is not necessarily based
on where they live.

Um, from our experience, we're
constantly sending referrals
everywhere in New York City.

MS. MOORE:  Okay.

MS. BREWSTER:  Paulette Brewster
with Queens Healthy Start.

To piggyback off of that. You
know, if the referral is sent to one
borough, they are entering it into the
system, there should be a red flag set
up that if a person is already, you
know, connected to coordinated intake
in the Bronx, it gets bounced back
there, so there is less duplication of
the referral, and less duplication of
services.

MS. WEST: Denise West.

One of the things I know people
hate to talk about is resources. So
ensuring that who you are referring to
have the resources to do the data
entry.

Oftentimes, they are expecting
people to do data entry, but there are
no staff resources, equipped, are
offered to be able to help do some of
that data entry piece.

MS. MOORE: Okay. Any other
comments on that?

MS. WEST: And to also set up
there, as my colleague said, the
 borough needs to talk each other. Sometimes they are outer layers, people are getting referred to services that may not necessarily be a part of the core referral unit.

How do they interact with the system is also important to identify, you need to filter that in with HIPPA, and all of those other things. How does that get incorporated?

MR. MOORE: So is there anything else here that kind of gives you a work-flow loop, that has been thought through, that would contribute to the success of the Coordinated Intake and Referral System, that's not outlined here?

MS. WEST: What is very basic is looking at all of the systems and the data everybody has, so that you are capturing at the beginning the information that is really needed.

Having participated in several systems over the years, we tend to
build out more, per the funder, and it doesn't ask this question, or it's not tracked, or asked in a certain type of way.

So really to ensure that while there are different programs, like, the Nurse-Family Partnership, the Doula Program, various programs. Not all of these programs have the same types of questions, so really you need to sort of map that out at the beginning.

What are the questions that really need to be asked? And key questions to ensure that it is not using a clinical model, that you also have a different social model thought through.

MR. MOORE: Okay.

MS. ROSA: Marci Rosa with Public Health Solutions.

I think there are outlines in the Concept Paper, but I want to reiterate the importance of there being a local
community advisory board that's making
the actual decision for that borough
and for that system.

It can't be dictated from the top.
The partners have to really build it
themselves and be comfortable with it,
or people aren't going to buy into it.

MR. MOORE: Before we move on, any
other comments to that question?

(No response.)

MS. MOORE: No? Okay.

The next question. What do you
see as the benefits of the Coordinated
Intake and Referral (CI&R) System in
your borough? What are the benefits?

MS. MAGGIE: Maggie.

I think the obvious benefit is
that if it is effective many more
families will be served primarily;
secondarily, the capacity will be
tapped, I think more effectively if
all of the existing programs that are
out there to serve.

MS. WEST: It reduces
fragmentation of care and really helps streamline it to get the individual to the appropriate services a little bit streamlined.

MS. MOORE: More benefits?

MS. CADET: Less duplication of outreach efforts.

MS. MOORE: What challenges do you foresee? What should be done or incorporated into the RFP to minimize these challenges?

So what challenges do you foresee, and what can be incorporated into the RFP to reduce or minimize these challenges?

Yes?

MS. BREWSTER: As Marci said, it really does need to come from the community. It should not be a top-down implementation, because community buy-in for any centralized intake, whatever we are going to call it, is very important.

These people are on the ground,
these are, you know, the people you need to get, you know, to get them speaking the same message to the community. If the players on the ground speak the same message, then the hospitals buy-in, the clinics buy-in, so that is very important.

They are able to develop a referral system; they are able to get input from whatever data system, whatever risk assessment is going to be used, so they feel this is theirs as well.

MR. MOORE: The second part of the question, what do you think can be put into the RFP?

MS. BREWSTER: I think the requirement for the advisory board, for there to be equal representation from top to the bottom. Equal representation in any advisory group is really important.

One last thing, that advisory group, to just not have
evidenced-based programs, but it includes local home-grown programs as well.

MS. ROSA: I would also like to add, I agree with everything Paulette said, but I would like to make a requirement in the RFP that all existing programs need to be a part of the application. You know, requiring letters of support or letters of cooperation from them.

Because what I think you don't want to happen is parallel tracks going on at the same time, as long as everyone is included in the proposal, then you know that they are all a part of one system, and they are not creating another system separate from it.

MS. MOORE: By application, you are saying an application to apply for the RFP; are you talking about technology?

MS. ROSA: The application to
apply for the RFP should require letters of cooperation from the home-visiting program.

MR. MOORE: Okay.

MS. ROSA: And the IT system that is ultimately developed should be the same system citywide, so that it could accept referrals from one borough to the next, then all of the data can be looked at citywide.

MS. MOORE: Okay. Other --

MR. BREWSTER: Paulette from Public Health Solutions.

There is one thing that Denise said about, um, the referral sources, and their buy-in, and how do we incentivize it for them to refer to the coordinated intake?

Since, you know, in other states there is a requirement through Medicaid they have to do this or that, they have to be referred to coordinated intake.

What is the motivation of the
referee to use the system, an
incentive, you know, some kind of
policy? So has there been any thought
for that?

MS. MOORE: Okay.

MS. TINAR: Camille Tinar with
Public Health Solutions.

Just to piggyback off of that, I
think whatever system is chosen is
something that is easily -- providers
are able to easily use and can be
integrated with their electronic
medical records system, that would be
really wonderful, so it's not an extra
thing for them to do.

MR. MOORE: Anything in addition
that needs to be or should be included
in the RFP, based on what we have
shared from these last set of
comments?

(No response.)

MS. MOORE: Okay. So we are going
to move on to the next question. What
functionalities should the electronic
platform, to be used by system, have?

MR. TINAR: Camille Tinar with
Public Health Solutions.

I think it should be -- there
needs to be a communication system
within the IT system, so that the
different players within the system
can communicate with each other. They
can say, hey, I am missing this field
from this referral, kind of an open
communication system.

And the other thing is a robust
reporting system where you can create
and customize the reports.

MR. ROSA: Okay. There has to be
a way to make sure -- Marci Rosa.
There has to be a way to make sure
that, um, there aren't duplicates in
the system.

MR. MOORE: There has to be a way
to do that.

MS. ROSA: There has to be a way
to do that.

Thank you.
MS. BREWSTER: Paulette Brewster with Public Health Solutions.

So any system needs to be intuitive. So if I put in a due date it should be calculating the gestational period, so things like that. If I put in a date of birth, it should calculate the stage.

It needs to be intuitive so the person doing the data entry is not spending their time calculating certain things. As few clicks as possible.

MS. MOORE: Okay.

MS. VALERA: Jasmine Valera with Public Health Solutions-Queens Healthy Start.

Camille said there should be open communication within the system. I think it should be both ways for the provider, so they will be able to go into the system and provide the referral feedback, so we don't have to spend so much time requesting
feedback. So to close the loop.

MR. MOORE: So the functionality should include closing the loop.

MS. VELERA: It should be -- the provider should be able to log into the system and access the system, and update things as needed, not just send the referral, and that is it.

MS. WEST: Denise West with Brooklyn Perinatal Network.

The system will have to have levels of authority and certain levels of rights, who can see what, that needs to be relatively consistent.

Also when it comes to ethnicity and race, there needs to be something that is standard, some systems vary in that. So some things need to be sort of standard and easy.

Similar to what Paulette was saying, something that is also easy so that when the staff is asking the client, it is easy for them to answer, so the language is really easy,
user-friendly. So that a client can be right there and can enter it into the system.

A lot of the questions in a lot of the systems that are used, the worker has to rearrange how they say it because it is not necessarily user-friendly. It's not language that you would really use in your interviewing.

The other piece, I don't know how people feel about it, when people do case management notes, they never get to the certain screen, and I don't know what can be done.

So that -- a lot of the meat is in the notes, and I don't know what can be done in the system to sort of pull out what really may be needed, it comes out of the case management type of notes, 'cause there are no dropdown boxes.

A lot of the meat is in the notes, but it takes a while before you get to
it; it's not easily accessible.

MS. MOORE: What is your ask for functionality?

MS. WEST: I am still thinking about that.

MS. YUNSEN: Kesha Yunsen with Family Care.

Are you considering, maybe having something that is standardized, where there is a check box, so they go through -- no?

MS. WEST: I don't think that is how a person actually does the work. I am not quite sure.

MR. MOORE: A place for notes for now.

Brandi?

MS. CADET: So to piggyback off of your comment, Denise. Some sort of search functionality, that also includes a listing of providers, that in addition to providing home visiting services, also provide other services.

Because I think there are a lot of
programs, as she mentioned, that have multiple service models. So if there is potentially a provider that can be a one-stop shop for multiple needs that tie into social determinants of health, we want to make sure families, if possible, are connected to those providers.

MS. TINAR: Camille with Public Health Solutions.

I also think that this system needs to have a built-in algorithm to get referrals for someone that already has a child, this is her second pregnancy, we know she is not eligible for NFP.

Once we put in all of the information about the client, we know it will spit out the programs that the family is eligible for.

MR. MOORE: Okay.

MS. MAGGIE: Maggie.

I think beyond things like, prior pregnancies, prior births, all of the
ZIP codes have to be in there too. Still today, many programs are very specific to the geographic area, and until that changes, also it's really important to have a system that we really understand what somebody is eligible for beyond that other piece of information.

MS. ROSA: Smart logic.

MS. MOORE: The presentation is in front you. What added value could the Coordinated Intake and Referral System provide for your organization?

MS. WEST: Denise with the Brooklyn Perinatal Network.

Any data collection is always good for future and further reporting and funding sources. So having really good reporting, and being able to pull data and show impact.

I would be interested in more than just quantitative data, but impact -- being able to show impact data over a period of time, of course, would be an
added value to us.

MS. ROSA: Marci Rosa.

First and foremost, funding and a real IT system, as opposed to Excel would be an absolute added value. But the biggest added value is being able to better serve the community.

MR. MOORE: Do you need time to think? Any more?

MS. MAGGIE: Maggie from SCO.

I also think we can improve the agency, if it works well, it will actually improve the quality and quantity of referrals going to any given program, which would itself be a huge efficient component.

MS. WEST: While we are focusing on mothers, women and children, I would say it needs to include services and things for men as well. So the families -- moms and children -- are not isolated from their family.

At least in our community, we do a disservice when we break it out and
separate it out, so it needs to include a family perspective with the services that are being offered.

    MS. MOORE: The next question. The current home visiting landscape does not have the capacity to service everyone who might be interested.

    What other types of perinatal service should people be connected to through the Coordinated Intake and Referral System?

    MS. WEST: When we talk about Doula for support care, some of it. The Doula services -- birth control, postpartum care -- should be included here.

    MS. CADET: Brandy Cadet.

    I would also -- there are lots of other perinatal services that are not home visiting models, so to add on to that, not evidence-based home visiting models.

    A lot of the feedback we often get from families, while they are
interested services, may not be able
to consent to home visiting due to
their housing situation or not they
are willing to do it.

So other models that would support
a more flexible approach to perinatal
services would be great.

MS. BREWSTER: Paula Brewster with
Public Health Solutions.

So it needs to include any group
education that exists in the
community, any classes, any support
groups, any centering pregnancy, any
organizations that do distribution of
supplies, crib distribution, WIC
services, food pantry, any of the
secondary services to home visits also
to be included in that.

MR. MOORE: Anything else?

MS. BREWSTER: Also high-risk
providers in the community, if it also
includes that. So any high-risk
provider, if that's included in the
system, that be included, as well in
mental health. Postpartum depression.

MS. WILLIAMS: Desiree with the Learning Center.

All I am saying it should include some child-care services for the family.

MS. ROSA: Marci Rosa with Public Health Solutions.

Our coordinated intake in Queens really tries to address any needs that come up for the family with the approach being trying to make sure that the family doesn't leave empty handed.

So also social determinants of health, social determinants of any type of health.

MS. MOORE: That is the final question on this slide. If you think of additional comments, we have a final slide that will give you information where you can provide those comments, if after you marinate on the information shared, you have
some additional thoughts.

I am going to share with you the estimated or approximate procurement timeline as it relates to the release of the RFP. So we project that the RFP will be released in the winter of 2019; it will be due the summer of 2020.

The decision will be awarded in the fall of 2020, so those are -- it is estimated procurement timeline.

Okay. As I said we welcome your comments through December 26th.

If you have comments you can e-mail them directly to RPF@health.nyc.dot.gov; indicate CI&R Concept Paper in the subject line of the e-mail.

Written comments may be sent to the following address that is listed:

Dara R. Lebwohl, New York City Department Health and Mental Hygiene, 42-09 28th Street, Queens, New York 11101.
Again comments are invited to be accepted through December 26th. Okay. So I want to thank you for all of your comments and feedback you have provided here today.

If you have not signed in, please sign the attendance sheet in the back. If you have not received a copy of the Concept Paper, I believe copies are in the back as well.

MS. WEST: Are you going to compile the comments and questions so that we can see them?

MS. ASHTON: Do you mean from this event today?

MS. WEST: You have another one in the Bronx, are you taking comments -- well, it's on my birthday.

MS. ASHTON: Happy birthday.

So the written comments we do -- Erika, correct me if I'm wrong -- the written comments, we respond publicly to the written comments on occasion, but I am not sure we made a decision
whether or not we are going to do that.

This is a Concept Paper, this is not a request for a proposal, this is not a standard solicitation. This is we have an idea, we want your input, we want your feedback. We will look into your input and feedback, we are hearing you today, and we are looking at the transcripts.

This is not a formal solicitation. So I think we are going to look at the transcripts, we will talk about whether or not we will release answers to these questions and go through them.

But the answer to, really, your question is, hopefully what is going to happen is we go are going to incorporate your feedback into the request for proposal that's issued next winter; and so that's the ideal outcome on this.

MS. BREWSTER: Paulette.
Will the data system identified be included in the RFP?

MS. ASHTON: If there is a data system that is identified by the time that the RPF is released, we'll consider including that in the RFP. At the moment it has not been solidified, nor the RFP release date has been solidified.

So I am guessing, when we release the RFP, it is in our best interest to put as much information in it, so we'll try to do that.

MR. MOORE: If you have additional comments that you want on the record right now, we'll take them. If not, again, you have information where you can share them.

Thank you.

MS. ASHTON: One last thing, the comments you submit are in response to the Concept Paper, they don't only have to be in response to the questions we asked today.
So as you read the Concept Paper, if you have other ideas you want to submit related to the Concept Paper, feel free to include that within your comments. It doesn't' have to be limited to what we discussed and the questions today.

Thank you.

(Hearing concluded 3:08 p.m.)
CERTIFICATE

I, Regina Dones, Court Reporter and Notary Public in and for the State of New York, do hereby certify that I attended the foregoing proceedings, took stenographic notes of the same, that the foregoing, consisting of pages, is a true and correct copy of same and the whole thereof.

Dated: November 18, 2019

Regina Dones
Regina Dones
NYC - Department of Health & Mental Hygiene
November 18, 2019

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LH REPORTING SERVICES, INC. 718-526-7100
THE CITY OF NEW YORK
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
COORDINATED INTAKE & REFERRAL FOR
MATERNAL AND INFANT/CHILD HEALTH HOME
VISITING SERVICES
LISTENING SESSION

November 20, 2019
10:10 a.m.
1826 Arthur Avenue
Bronx, New York

Julia M. Speros
Court Reporter

LH REPORTING SERVICE, INC.
Computer-Aided Transcription
718-526-7100
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Shanequa Moore
I'Raie

Charu Sood
Montefiore

Shamise Quinn
Community Health Center of Richmond

Sada Malik
Haleema Blessing Daycare Inc.

Madeleine Moller
NMPP

Mary Brown
EGF
MS. ERICKA MOORE: Okay. So good morning everyone. Thank you for your patience. We were just trying to wait for a few additional people to come in.

My name is Ericka Moore. I am the Director of the Maternal and Child Health Unit at the New York City Department of Health and I will be your moderator this morning.

We also have in the room Ms. Kim Freeman, who is the manager --

MS. FREEMAN: Yup.

MS. ERICKA MOORE: -- who is the manager here at the Bronx Neighborhood Health Action Center and some of you may know her and have engaged with the programming here as well.

This morning we will going through some slides and reviewing -- the purpose of this meeting -- this listening session -- is to provide you with information regarding a Concept Paper that was recently released related to the Coordinated Intake & Referral
System.

I will be reviewing some slides and reading them exactly as they are, and then after that, I will ask you some questions and we would like your feedback related to this Concept Paper, which will be used to finalize the RFP that will be coming out in winter of 2020.

To document all your comments, we have a stenographer here who will be documenting everything that we say, so we ask that everyone, when you're speaking, please say your name and speak loudly so that she can accurately document what you are saying.

Okay. And so we can begin. So the overall -- the first slide is -- objective -- let's go back -- go back -- yes.

So the objective of the Concept Paper:

The Department of Health and Mental Hygiene seeks to improve maternal and infant/child health and wellbeing
outcomes by matching families' assessed risks to evidence-based or evidence-generating home visiting models through a Coordinated Intake & Referral System.

DOH proposes to issue an RFP to procure services from qualified organizations to serve as the borough-based operators for a Coordinated Intake & Referral System for maternal and infant/child home visiting services in New York City.

The overall goal is to ensure that New York City families have access to appropriate evidence-based/evidence-generating home visiting models by establishing a Coordinated Intake & Referral System that incorporates a range of models from low to high intensity.

The Coordinated Intake & Referral System will provide New York City families with a single point of entry for maternal and infant/child home visiting services and other services as
needed.

The families will be matched to appropriate services based on their needs and preferences. The system will also efficiently manage referrals and track referral outcomes.

So the Coordinated Intake & Referral infrastructure includes technology for system operations and data management, risk assessment for families in order to match them to the best home visiting model that meets their needs, system efficiencies by centralizing client/family intake.

So that was the extent of the slides that we have and those slides were taken exactly from the Concept Paper, which all of you have access to and have in front of you.

And now I will begin a series of questions that I will be posing to the group and ask for your feedback.

As a reminder, we ask that when you're providing feedback that you state your name, the organization in which
you're affiliated with, and then speak loudly so the stenographer can capture what you are saying.

Okay. So the first question is:

A tremendous amount of work has been conducted across the City to develop regional Coordinated Intake & Referral Systems. Our goal is to learn from these existing programs and to build upon the work to date.

Based on lessons learned, what successes should be incorporated into the Citywide effort? That's the first question.

So what successes should be incorporated into the Citywide effort?

MS. SHANEQUA MOORE: Hi. My name is Shanequa Moore.

I don't know specifically what successes have already been, but a success that should probably be considered is some type of data-sharing across systems so most clients that go through certain systems like -- whether it's the shelter system or whether it's
needing additional -- needing insurance
-- they're normally recipients of
certain service providers or
community-based organizations -- so some
type of data-sharing system where these
clients -- where there's kind of like
more of a coordinated care system so
that service providers, that also
services that family, that there's some
collaboration and co-creating across the
board.

MS. ERICKA MOORE: Okay.

MS. MALIK: Hi. My name is Sada.
I'm with Haleema Blessing Daycare in Brooklyn.

Yeah, what I would suggest is -- I notice -- okay, so there's a lot of low income families now; there's a lot of single mothers. That has a huge impact on the child's growth and how they react. They become rebellious; they don't listen.

So I feel like there should be a system where they can go to the families and speak to the families individually
-- the mother, what she needs -- or the child, what the child needs -- or the father -- how they can, you know, basically implement the system where there's either more togetherness in the family or you can help like financially as the grants or -- stuff like that.

Like, you know, being more involved in the family because I notice that in New York City, there's a lot of low income families now, even in Brooklyn. So -- yeah.

MS. ERICKA MOORE: Okay. Any other comments?

MS. QUINN: Hi. Good morning. My name is Shamise Quinn. I'm with the Community Health Center of Richmond.

I think one of the successes that should be incorporated into a Citywide effort is the ability to closely follow and monitor a family or someone who comes in for their central intake.

A lot of times they get lost in a system, and even though a lot of systems may be shared by multiple organization,
the progress of that family is still lost.

So strict documentation of families as they go through each referral and with a -- like a finalized outcome at the end of their case if it's closed or whatever -- or if their major problem is solved, to document that.

MS. ERICKA MOORE: Okay. And so in the work that you know that has been done in this area, what has not worked?

MS. SOOD: My name is Charu Sood. I'm from Montefiore.

I think in our programs the number one thing we struggle with is what happens after we make the referral.

There needs to need some sort of way of tracking what is the outcome of that referral so that, you know, we can see what happened, especially with families that kind of repeat and keep going in and out systems so that we can try to understand why it didn't work out instead of doing the same thing over and over and over again.
MS. ERICKA MOORE: Okay. Any other comments of what has not worked in these efforts?

And even though it may get repetitive, please continue to say your name and the organization that you're from.

MS. QUINN: Okay. Shamise, Community Health Center of Richmond.

I think one of the things that does not work is that there's so many home visiting models who do the same work, and a lot of those organizations that provide those services, they do have slight differences and I think that some families may be missing out on a service because it's considered duplication of services.

So I think that hinders some families from getting some of the services that they need.

MS. ERICKA MOORE: Anything else before we move onto the next question?

(No response.)

MS. ERICKA MOORE: Okay. So the
next question:

So the Concept Paper describes the contractor's roles in general as:

Partnering with community-based organizations that currently deliver home visiting services, working closely with the Department of Health Community Advisory Committee, social service agencies, and community-based organizations to guide development and implementation of the Coordinated Intake & Referral System and provide ongoing input, conducting data entry and management for the entire process from receipt of the referral to the home visiting program assignment and communication back to the referral source, if authorized.

Is there anything else that would be important for the development and implementation of the Coordinated Intake & Referral System?

So this is like the work flow; so is there anything missing in those bullets?

MS. SOOD: I guess the main question
that I have --

MS. ERICKA MOORE: Can you say your name, please?

MS. SOOD: Sorry. Charu Sood from Montefiore.

I think the main question that I have from that is kind of being a little bit more concrete about what data is being shared and how -- not just from the CIR that's developed, but also from the other agencies back about outcomes of the referrals that are made. Just kind of really make that a little more concrete and clear about what the expectations are around that.

MS. ERICKA MOORE: So outcomes back?

MS. SOOD: Mm-hmm.

MS. ERICKA MOORE: Okay. I know that's a lot of information to process so give you a few more minutes to read through the slide.

(Attendees Perusing.)

MS. ERICKA MOORE: So is there anything else that should be considered to contribute to the success of the
Coordinated Intake & Referral System?

MS. MALIK: I agree with her --

MS. ERICKA MOORE: Say your name

and --

MS. MALIK: Sada, Haleema Blessing.

I would agree with her on the concrete data, just proposing a plan -- a yearly plan and being like transparent where we can see the progress of the referral just -- yeah, a proposed plan, like where you have PowerPoint where we can see how -- you know, how we have improved or how we haven't succeeded but -- yeah.

MS. ERICKA MOORE: Okay.

MS. QUINN: I'm sorry -- Shamise again from the Community Health Center of Richmond.

I didn't read all this -- I don't know if it's included, but what about like administrative responsibilities for like that -- for the contractor -- is that -- first all, for clarity, the contractor is like that primary organization that's conducting the CIR,
so what about like administrative like
duties or --

          MS. ERICKA MOORE: Can you fine-tune
          that a little bit more; what would you
          consider administrative duties?

          MS. QUINN: If they have to hold any
          meetings or things of that nature maybe
to discuss like, you know, work flow of
how the CIR process is going between
organizations, and then if there are
risks involved, or any issues that nay
be, you know, happening, or any bumps in
the road; things of that nature.

          MS. ERICKA MOORE: Okay. So we're
going to move onto the next question.

          Since you are just joining us, we're
reviewing the questions and asking for
feedback. If you have feedback to any
of the questions, we just ask that you
state your name, organization you're
affiliated with, and speak loudly so the
stenographer can capture what you're
saying.

          Okay. So the next question is:

          What do you see as the benefits of a
Coordinated Intake & Referral System in your borough; what are the benefits to having a Coordinated Intake & Referral System in your borough?

MS. SHANEQUA MOORE: Shanequa Moore from I'Raise.

I think the benefits of it is it allows universal system for people to access and it allows accessibility for families and parents to be able to get to services.

A lot of times parents or families don't know what's out there; they don't know what's in their neighborhood. They don't know how to access certain things.

I think that's the number one issue. A lot of times in certain districts, it's like, "What's there"; "I don't know how to get to it". So having a universal system for people to be able to know -- building awareness and being able to access the services, I think that's a really great -- that's a benefit.

MS. MOLLER: Madeleine Moller from LH REPORTING SERVICES, INC. 718-526-7100
NMPP.

I think it also avoids duplication because some of the clients, they (sic) are so many -- they are involved in so many organizations, and in the same, they might have -- attending the same programs, the same services.

And I think that's kind of like streamline the services for them and it does avoid duplication and also it's more important to the client because it's sometimes too much and confusing for them. I think it's a good -- the Coordinated Intake is a good thing.

MS. ERICKA MOORE: Anymore benefits?

MS. MALIK: Sada from Haleema Blessing.

I think it's a great tactic; a different approach. Like, you're closing all loose ends in a way. So it's a different approach where you can tackle the referral, like -- I mean, not in like literally the sense -- but like tackle the referral in a way where you can help improve the child.
And, you know, you're trying all different ways, whether it's family involvement, whether it's in a daycare, or whether it's community services, you're not leaving any loose ends. So you can see the improvement in the child's mental health and family growth.

MS. ERICKA MOORE: Anymore benefits?

(No response.)

MS. ERICKA MOORE: So what challenges do you foresee, and if you see any challenges, what should be done or incorporated into the RFP to minimize these challenges?

MS. QUINN: (Indicating.)

MS. ERICKA MOORE: Go ahead.

MS. QUINN: All right. So I'm Shamise from the Community Health Center of Richmond.

I think one of the challenges I foresee is favoritism, maybe, amongst organizations. I think it's really important that there's a neutral convening body who is the, you know, contractor for the CIR System only
because I'm speaking for myself.

Staten Island is very small and we don't have as many home visiting programs I guess as the other boroughs, but we do see that, you know, there are some organizations -- you know, the EDs are very close with each other.

You know, we just want to make sure that families, you know, are being referred and getting the correct services, not based on favoritism, but based on that particular need and ensuring that that particular organization fulfills the needs of those families.

MS. ERICKA MOORE: Any other challenges?

(No response.)

MS. ERICKA MOORE: No? So we're going to move on.

MS. SHANEQUA MOORE: I have one; I'm sorry.

MS. ERICKA MOORE: Okay.

MS. SHANEQUA MOORE: Shanequa Moore from I'Raise again.
I'm not really familiar with the home visiting model too much, but a challenge that comes to me is temporary housing. Families that are not as stabilized that are moving from different places, that may not have permanent or secure housing.

And then another one is how we measure impact and how we're measuring success. When we're measuring outcomes, what does it look like; what are we measuring? What's the baseline?

And that would kind of like -- when we're tracking them throughout the process of referral, measuring impact and success.

MS. ERICKA MOORE: Okay. And so with any -- with the challenges that were provided, do you have any suggestions regarding what could be included into the RFP to minimize the challenges?

So you mentioned favoritism.

MS. MOLLER: Well, one question that was said, I think it should be --
MS. ERICKA MOORE: Your name.

MS. MOLLER: Madeleine from NMPP.

I think there should whoever the main -- the lead agency is, so they should have, I think, a set number of referrals are made to partnering agencies and then probably when they decide on capacity -- and then so you can say, well, one agency gets, let's say, 15, 20 referrals and the other one got one.

So you can -- depending on the size, there could be a range of referrals that the lead agency has to refer to other partnering agencies to ensure that everyone has a set of plans to work with.

MS. ERICKA MOORE: Okay.

MS. SOOD: Charu from Montefiore.

I think one of the things that we haven't talked about is what the intake process would look like and I think that might be a space to be very concrete with what information we're collecting and kind of use that information to
create a decision-making process about which agencies to refer to for various needs, which could help address issues of favoritism to have a very concrete intake process.

MS. ERICKA MOORE: Okay. Any additional ideas, thoughts regarding this question?

(No response.)

MS. ERICKA MOORE: Okay. So we'll move onto the next.

What functionalities should the electronic platform (to be used by the system) have?

So what functionalities?

MS. SOOD: Charu from Montefiore.

I think it's really important that multiple agencies have access to it so that everyone can really share information about clients you're making referrals for.

MS. SHANEQUA MOORE: So, yeah -- Shanequa Moore from I'Raise.

Definitely being able to share the information across the referrer -- the
partner agencies, community-based agencies, social service agencies, which I feel like a lot of information is either duplicated, or goes missing, or it's not efficient -- nonworking numbers and things like that --

But also, I'm wondering if there would a piece for parents to be able to access the system; the accessibility of parents to be able to get information from the system in terms of the referral source.

I'm thinking like for our agency when we get referrals from, like Montefiore or other places, when the information comes to us, sometimes a lot of information gets lost in translation, and then also parents being able to -- access those clients is -- sometimes there's a barrier there.

So how much accessibility would the system have for parents or for people that we're serving?

MS. ERICKA MOORE: And the parents have access to it -- like what types of
information --

MS. SHANEQUA MOORE: Probably like, this is the agency that we referred you to; this is the contact person. This is their number, their email, and then coordinating that for the parent at the same time but giving them that information.

MS. MOLLER: But not access to the system?

MS. SHANEQUA MOORE: Right. Not -- I mean, obviously there's different levels of access that you can give people, so maybe something like a client portal. I don't know -- there'd probably be like a better term.

MS. SOOD: So they can't quite read the notes that we're reading.

MS. SHANEQUA MOORE: Right -- right.

MS. ERICKA MOORE: They wouldn't have access to everything.

MS. SHANEQUA MOORE: Right.

MS. MOLLER: That would be a violation.

MS. ERICKA MOORE: This is just
we're throwing out -- we're brainstorming ideas.

So any additional ideas on what functionalities should the electronic platform to be used by the system have?

MS. MOLLER: I think -- like what she said, I think the referral agency people should have -- all should have access because -- not the parent, like you said -- like if I refer a client to another agency, one agency refer, and then they -- all of the partnering agencies who are part of it should have equal access so they can see when the referral was made, when the client was visited -- contacted.

So we know the referral was made and then it was accepted and the services are provided, and then that way we know the clients are being served.

MS. SOOD: Charu from Montefiore.

It would also be great if somehow the electronic platform could serve as a database for the various programs around the City because I think even as a
provider, it can be difficult to keep up with all the services available.

And so if that could somehow be built in, that would be very helpful.

MS. ERICKA MOORE: And when you're saying "database", can you elaborate more what you mean by that?

MS. SOOD: I mean, something even as simple as just a list of -- you know, for housing, these are the options, or for -- you know, just home health visiting services, these are the agencies around the City. For mental health, these are the agencies.

If that could kind of be taken a step further and built into some sort of, you know, decision tree or something, that we're putting in this information about a client so it will say, "Oh, you need mental health so here are the mental health agencies in your borough" or something like that. That would be really helpful.

MS. ERICKA MOORE: Okay. This is your wish list so throw it out.
(Laughter.)

Okay. So we'll move onto the next question.

What added value could a Coordinated Intake & Referral System provide for your organization?

MS. SOOD: So it's Charu from Montefiore.

I think one of the main values is that it would be a way to access the clients that are very difficult to get in to the office setting.

I think particularly when you're talking about new moms that may have mental health concerns or substance abuse concerns, it can be very difficult to get them in the door even though you can give them appointment after appointment. And so having a system that will sort of follow-up with them and really follow them for a while in close detail, is very helpful. It will help people from falling through the cracks.

MS. ERICKA MOORE: Any other value?
And speak as much as you want; don't feel like you've contributed too much; again, the information that you share will help with finalizing the RFP.

So it's really important that we get your feedback, and so I want to give you the time to think about each of the questions and time to provide your response.

MS. SHANEQUA MOORE: I like the -- Shanequa Moore from I'Raise.

I like the idea of the matching and it being what the client -- or centered on client needs and preferences versus saying, "This is what you need", but kind of giving them that power to say, "This is what's best for my family" or "This is what I'm ready to address".

I think a lot of times we tell clients, "You need this", "You need that", and they're like, "I'm not ready to deal with that right now".

So allowing them to choose what they want and what they need for their family, I think giving them that power
is very valuable.

MS. MALIK: I agree with that.

MS. ERICKA MOORE: Any other added values for your organization?

(No response.)

MS. ERICKA MOORE: Okay. So we'll move onto the next question.

So the current home visiting landscape does not have the capacity to serve everyone who might be interested. What other types of perinatal services should people be connected to through the Coordinated Intake & Referral System?

So are there other services beyond a home visiting program that should be included in this system, and if so, what are they?

MS. MOLLER: Well, I would say doula services, that should be added to it. And what else -- midwifery for this -- I mean, that can also be added because there are folks who also could make home visit, especially I'm thinking of postpartum visit and then the doula
services would be something very helpful for the client.

MS. ERICKA MOORE: And, again, this could be beyond and does not necessarily need to include home visiting.

So if there are other types of services that families with young children may need, beyond home visiting, what would that be?

MS. SHANEQUA MOORE: Shanequa Moore from I’Raise.

Child care is a huge thing for parents. A job -- work force services so parents, after having a child, being able to get back into the work force. And with that comes child care; making sure they have the appropriate child care services to be able to go to work and to have income.

Domestic violence services. A lot of time there's parents that need those services; so outsourcing to those different agencies.

MS. FREEMAN: Kim Freeman, Tremont Neighborhood Health Action Center.
So some of the services that we have in this building as a Department of Health agency, we have a family wellness suite. I think also -- and we provide services to families with young children and women in their preconception to after delivering their child.

Also, I think having access to fitness classes, to those types of services that could help a mom get back on track. It could be other wellness classes like yoga, mommy-and-me, meditation. Things like that will -- that could help a person deal with the stresses in their life.

MS. QUINN: Shamise from Community Health Center of Richmond.

Of course, while the woman is pregnant, you know, to piggyback on her, doula services, breastfeeding, lactation counseling to help with those particular birth outcomes.

Even when she has given birth -- we come across a lot of parents who do want to be referred to, like, other mommy
groups because they're tired of being in the house all day with the baby.

Domestic violence, of course, you know, basic needs being met such as food, pantries, housing. That's it.

MS. MOLLER: Social services.

MS. QUINN: Social services.

MS. ERICKA MOORE: State your name, please.

MS. MOLLER: Madeleine Moller from NMPP.

I would say, I mean, clearly what everyone is saying. Say all the social determinants that the client need, especially food pantry. It's also big deal.

MS. ERICKA MOORE: We'll go this way and then come back to you.

MS. SOOD: Charu from Montefiore.

I think one of the things that we find new moms are very interested in is just general education about parenting. With babies, they have a sense that the guidelines keep shifting, but they don't necessarily know what they are,
especially around like safe sleep, and breastfeeding, and all that stuff.

So some way to kind of give them education about that.

MS. ERICKA MOORE: Okay.

MS. MALIK: Sada from Haleema Blessing Daycare.

Consultations with the mother if she's going through something because usually if the mother is stressed out it affects the child. Just seeing the progress of the child and getting to spend time with the mom, and educating her -- like she said -- and whether it's parenting or it's psychology --

So if she has an issue or if her child has a psychological issue, she can be educated and tackle it, you know, firsthand because she will obviously have a higher affect on the child compared to -- we will -- we can provide as many services as we want; we're only there for a certain time.

Another thing is making child care more affordable because there's a lot --
like the neighbor I'm from, there's a
lot -- there's the most need; a lot of
low income mothers who are struggling to
provide for their children and they have
to leave their child at child care.

We tend to help to help them out at
times. Even if they can't, we'll do pro
bono, but -- yeah, so making child care
more affordable, but then at the same
time not making work so overloaded on
the mother where she can't spend time
with the child as well.

So finding out what the specific
needs are for that specific family.

MS. ERICKA MOORE: Okay.

MS. MOLLER: And one more thing,
mental health services as well.

MS. ERICKA MOORE: Okay. You have
her name?

THE STENOGRAPHER: (Nodding.)

MS. MOLLER: Madeleine Moller.

MS. ERICKA MOORE: Okay. So next
question -- so actually, that was the
final question.

And so this is just an approximate
procurement timeline, and so we expect that the RFP will be released in winter 2020. The proposals will be due summer 2020 and we will award decisions in fall of 2020.

MS. MOLLER: Will the proposal be posted on HHS -- on HSS?

MS. ERICKA MOORE: So the proposals, I believe, will be posted there.

Odette, proposals posted?

MS. HARPER: Yes, they're usually posted on our site; the DOHMH website.

MS. MOLLER: Okay. But not necessarily on HHS because somebody forward that to me mistake, but I didn't get this from HHS. So I --

MS. HARPER: It's not -- the RFP is not ready yet. This is just a Concept Paper.

MS. MOLLER: Yeah, I know -- I know. Right.

MS. HARPER: If it's in Accelerator RFP will be posted --

MS. MOLLER: Accelerator --

MS. HARPER: Yeah, but you have to
be signed up with Accelerator to get access to all the RFPs.

MS. MOLLER: Yes.

MS. ERICKA MOORE: So the bathroom is right outside to the left.

Okay. So next slide, Craig.

So contact info (sic):

So we are accepting comments through December 26, 2019. If you have comments, you can email them to RFP@health.nyc.gov and indicate CI&R Concept Paper in the subject line of the email.

Alternatively, written comments may be sent to the following address, Dara -- I don't want to mess up the last name; you see it there -- New York City Department of Health and Mental Hygiene, 42-09 28th Street, CN 30A, Queens, New York 11101.

And so if you have any comments after today, after you reread the Concept Paper, look at the slides and you need some more clarity, you can send an email to that email address and
someone will get back to you.

That's the final slide.

Any additional thoughts on any of the other questions -- any of the questions that we went through that have come to you that you would like to share before we conclude this session?

MS. MOLLER: Yeah, I mean, I didn't go -- I didn't read the whole thing and then I came late -- how many awards will be granted; just one?

MS. ERICKA MOORE: So right now it's one per borough.

MS. MOLLER: Oh, one per borough. I see.

MS. ERICKA MOORE: One per borough.

MS. MOLLER: Okay.

MS. ERICKA MOORE: Again, funding permitting.

MS. MOLLER: Of course.

MS. ERICKA MOORE: Right.

MS. MOLLER: Right. So there will be five?

MS. HARPER: Yeah, so please keep in mind, this is just a Concept Paper.
MS. MOLLER: Yes.

MS. HARPER: So depending on the feedback that’s given, the program might change their mind, and depending on — no, no, that’s the real — that’s a real fact.

So depending on the feedback that you get and funding available, that may change. But in the RFP, all that will be listed out when it’s released.

MS. MOLLER: Okay.

MS. ERICKA MOORE: So this is a Concept Paper like Odette said. So nothing is final in here; this is our — this is our idea.

MS. MOLLER: Sure.

MS. ERICKA MOORE: And, again, we're hosting these listening sessions for feedback. So depending upon the feedback that we get, coupled with funding availability, then those final decisions will be made once the RFP is posted.

MS. MALIK: I have a question:

So what is the DOHMH — what’s the
whole agenda behind it; what outcome do
they expect, like, from us as
contributors? Like what do they expect
of us; what is the expectation for us to
exceed?

MS. ERICKA MOORE: So the
contractors' responsibilities were on
one of the slides, as is listed right
now in the Concept Paper.

MS. MALIK: Yes.

MS. ERICKA MOORE: So right now,
that's all we have.

MS. MALIK: Okay.

MS. ERICKA MOORE: Right. And,
again, as stated, nothing here is final.
This is just a basic framework and we're
listening to the community to really add
to that and enhance based on your
feedback.

MS. MALIK: Okay.

MS. QUINN: Just one of the things
that comes to me, just from -- I run a
nonprofit in New York City -- is what is
going to be done with -- in terms of
capacity building for nonprofits and for
community-based organizations that may receive an influx of referrals; will there be any support or capacity built in for those?

So I'm stating for us, like if we just got 100 and something referrals tomorrow, like what we would do; how would we build capacity to be able to accept them and be able to service those clients?

MS. ERICKA MOORE: Okay. So that's a comment that will be on record. Okay. Any other additional comments?

MS. GORDON: Hi. My name is Tionne Gordon. I used to work for DOHMH. I'm a Budget Analyst.

I don't know too much about the program, but the question I had was, do you have a targeted number of families that you're trying to serve in terms of like how many -- like what type of money you're asking for and how many families is that going to serve; like what's the targeted population.

MS. ERICKA MOORE: So all of those
details, again, are still being worked out and we have to see what funding is going to be made available to determine what that looks like.

The purpose of this is to really streamline and coordinate referral sources so that it really helps with the efficiencies of the process.

MS. GORDON: Okay.

MS. ERICKA MOORE: Right. So this will be a single point of entry for families, and then families can be routed to the home visiting program or resources that meet their needs and preferences.

Right. But, of course, we're still in -- the funding has not been finalized and all of those things then have to be taken into consideration of course.

MS. FREEMAN: Hi. Kim from the Tremont Health Action Center.

Just thought of challenge; what will be in place for IT issues that may come up with the system? Will people who are currently in the spaces be trained on
how to address those; who will be that person? The uptake, the use of the system; you know, how -- what's the plan for that, in addition to, you know, changing a culture of places who might be using paper systems right now?

Like, what's in place to make sure that this electronic platform is successful in places that may have a shorter smaller version -- or whatever -- of something like this?

MS. ERICKA MOORE: So are there like concrete things from what you just said that you feel need to be in place to get us to that point?

MS. FREEMAN: Yeah, I guess. So I think there should be certainly some upfront parameters in terms of like how the system works; how it's integrated into the current system. How the IT people at the organization, or whoever the point person is who handles it.

I think people would need to have all of that stuff upfront to understand how this system either would -- and I
believe someone mentioned -- talk to other systems, like where all -- you know, people would need to get that stuff. I think early on and often and transparent.

MS. ERICKA MOORE: Okay. Any other --

MS. SHANEQUA MOORE: Just one more comment that I've been thinking about the whole time.

I'm thinking of what role Child Protective Services may play and a collaboration with Child Protective and this particular model cause I assume that most of the population may have had some type of case or open case, or may -- they may be at risk for some type of ongoing Child Protective case --

So, like, what role would they play in this?

MS. ERICKA MOORE: So, what role do you think they should play; what type of access do you think they should have?

MS. SHANEQUA MOORE: I see it as dual. Like, on one end I see it as it
could potentially scare families away. It could be potentially be something that's stigmatized for families and they may not want to access the services because there's collaboration. But on the other end I think it's important to collaborate if you have parents or families that have involvement with CPS, collaborating with them -- cause they'll obviously be getting other home visits from other service agencies like CPS, whether it's preventive services -- whether it's an open case --

But like there has to be collaboration, but how do we work together to decrease stigmatization and reframe the services so that they can still access it?

MS. ERICKA MOORE: Okay.

MS. FREEMEN: Kim, Tremont Health Action Center.

We should all -- the system should also have something for legal -- how to access legal services in the community.
I'm not sure if that was mentioned, as well as -- so with legal services, what it looks maybe for their partners. If they could help their partners who might have a touch with the justice system. You know, just things like that. I haven't thought it out yet, but, yeah, something along those lines.

MS. ERICKA MOORE: Okay. All right. So that concludes our presentation today.

You have a copy of the slides. Please feel free to write in any additional comments that you have. Your feedback is extremely important to finalizing the RFP and having the communities' input before the RFP is finalized.

So your comments, your questions are extremely important for us to really try to get this right, okay, because it's important for our families in New York City that we do get this right.

Okay. So thank you so much for your time today, for all the information that
you shared, and, again, we invite comments through December 26th.

Have a good day everyone.

(Time noted: 10:55 a.m.)
CERTIFICATION

I, JULIA M. SPEROS, a Notary Public for and within the State of New York, do hereby certify:

That the witness whose testimony as herein set forth, was duly sworn by me; and that the within transcript is a true record of the testimony given by said witness.

I further certify that I am not related to any of the parties to this action by blood or marriage, and that I am in no way interested in the outcome of this matter.

IN WITNESS WHEREOF, I have hereunto set my hand this 20th day of November, 2019.

[Signature]

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NYC - Department of Health & Mental Hygiene
November 20, 2019

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