New York City Council Hearing

Access to Mental Health Services in New York City Hospitals

Committee on Hospitals
&
Committee on Mental Health, Disabilities and Addiction

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NYC Health + Hospitals

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Good morning Chairperson Rivera, Chairperson Louis and members of the Committee on Hospitals and the Committee on Mental Health, Disabilities and Addiction. I am Dr. Charles Barron, Deputy Chief Medical Officer of the Office of Behavioral Health, and Medical and Professional Affairs at NYC Health + Hospitals (Health + Hospitals). I am joined this morning by Dr. Omar Fattal, Deputy Medical Director for Behavioral Health and Dr. Rebecca Linn-Walton, Senior Assistant Vice President for Behavioral Health at Health + Hospitals. I am happy to testify before you today to discuss mental health services at Health + Hospitals.

Health + Hospitals is the main provider of behavioral health and inpatient psychiatric care services in New York City, with over 1,300 licensed psychiatric beds – representing about half of all psychiatric inpatient beds in the metropolitan area. As such, we provide a significant portion of behavioral health inpatient services in New York City, which underscores the need for continued stability in the public hospital system. Our inpatient services provide individualized, therapeutic care to stabilize mental illness episodes and promote rehabilitation, recovery, a return to the community, and less restrictive modalities of care. In addition to inpatient psychiatric services, our acute care behavioral health services include seven adult, and one child & adolescent comprehensive psychiatric emergency programs (CPEPs), which include psychiatric emergency rooms, extended observation beds,

mobile crisis intervention services, and access to crisis beds as well as four psychiatric emergency departments (EDs), which are psychiatric-specific areas of the regular ER.

Health + Hospitals provides a comprehensive array of ambulatory behavioral health care programs, including eight mobile crisis teams, outpatient clinics, day treatment, partial hospitalization programs, and case management behavioral health programs. For those patients who require significant levels of support, our facilities operate Assertive Community Treatment (ACT) Teams. The ACT Team program functions as a "clinic without walls" treating individuals in their homes and community. Of the 38 ACT Teams in New York City, Health + Hospitals operates 12.

Children and adolescents receive services through developmental evaluation clinics, family support programs, adolescent treatment programs, school-based programs, and outpatient clinics. Pediatric psychiatry emergency services are available at all 11 acute care hospitals, with Bellevue boasting the only Child and Adolescent Comprehensive Psychiatric Emergency Program (CPEP) in New York City. In addition to emergency services, Health + Hospitals offers pediatric inpatient services and the innovative OnTrack NY First Break program at its Bellevue, Elmhurst, and Kings County locations. Apart from the services provided at its acute care facilities,

Health + Hospitals also offers ongoing therapy, psychiatric evaluation, medication management, and other clinical services at 12 outpatient mental health clinics throughout the city. Through these clinics, Health + Hospitals launched the new Pathways to Care program in collaboration with the Office of Community and Mental Health (OCMH) and the Department of Education (DOE). Recognizing the need to bring additional support to children in the neighborhoods most affected by the pandemic, Pathways to Care expedites referrals from schools to connect students to care at our outpatient mental health clinics.

Harmful substance use is a significant population health problem in NYC, and Health + Hospitals is a major provider of substance use services. Each year over 90,000 unique patients with substance use disorder (SUD) come to us for care. Approximately 20% of primary care patients are at moderate risk of substance use disorder (SUD). Of our patients with SUD, about 15% have a primary diagnosis of opioid use disorder; and 45% have a primary diagnosis of alcohol use disorder.

To respond to this need, Health + Hospitals facilities provide an extensive array of SUD services.

- Outpatient intensive detoxification is provided in four facilities;
- 13 outpatient SUD counseling programs;
- The largest SUD Peer Counselor workforce in NYC;

- Four methadone treatment programs; and
- Growing SUD support for families, adolescents, and women in medicine

As part of the $7 million annual investment from *Healing NYC*, the Mayor's initiative to reduce opioid overdose deaths in NYC, Health + Hospitals has implemented several initiatives, including specialized funding for:

- Consult for Addiction Treatment and Care in Hospitals (CATCH)
- Buprenorphine Expansion in Primary Care
- Emergency Department Peer Advocates Addressing Substance Use
- Judicious Prescribing Training and Guidance

Most recently, in October, Health + Hospitals received a $1.8 million award from the New York State Office of Addiction Services and Supports (OASAS) to expand services to opioid and stimulant use in underserved communities of the Bronx, Manhattan, and Queens. The funding will help coordinate emergency department substance use access, Consult for Addiction Treatment and Care in Hospitals (CATCH) programs, outpatient services, and virtual access to substance use care, and bridge between SUD and psychiatry for patients with co-occurring mental health and SUD diagnoses. This vital funding facilitates a unified system of care so that New Yorkers can easily access quality support for substance use. We expect that

thousands of new patients will be served through this expansion of services made possible through the additional funding.

When COVID-19 saw its first case in New York City in March 2020, Health + Hospitals was at the forefront responding to the needs of its patients and the City overall. Behavioral Health has continued to play a vital role in the COVID response. Amidst unprecedented circumstances, Health + Hospitals kept its doors open so that New Yorkers could safely access care. We utilized all modalities, including in-person, telephonic, video calls, home visits, and mobile crisis outreach, to provide care. Working hand-in-hand with the Department of Health and Mental Hygiene (DOHMH), OCMH, the NYS Office of Mental Health, and OASAS, Health + Hospitals ensured coordination of all available behavioral health beds across all hospitals. To accommodate the surge in critical COVID-19 patients, Health + Hospitals worked as one system to safely transfer behavioral health patients to other facilities that had capacity, even standing up COVID+ psychiatric units in several hospitals.

Prior to COVID-19, Health + Hospitals had not conducted telemental health sessions; all sessions were held in person. When the pandemic began, telemental sessions rolled out in psychiatry, substance use services, the Family Justice Centers

for domestic violence victims and families, Addiction Consult teams for both Med ED and Inpatient Medicine, and mobile treatment (both mobile crisis and assertive community treatment teams). To help make this possible, Health + Hospitals distributed iPads to inpatient/ED behavioral health consult services. To date, Health + Hospitals has completed 350,000 behavioral health sessions telephonically and virtually.

Other initiatives launched during the pandemic are the Virtual Bupe clinic created to provide same-day buprenorphine access to existing and new patients. Our Virtual Bupe Clinic Pilot at Bellevue Hospital served 553 patients. We also partnered with the State DOHMH and OASAS to provide methadone delivery to patients on quarantine at hotels and in their homes, or to stable patients who were at high risk of complications from COVID for whom it was not safe to attend in-person sessions. For New Yorkers who required quarantine at a Test & Trace hotel, we provided access to behavioral health services. Once COVID-19 vaccination outreach began, and Test & Trace launched the Street Health Outreach & Wellness (SHOW) mobile units, we also began providing free mental health screenings on the units.

Health + Hospitals has a long history of taking care of the most vulnerable New Yorkers, and will continue to do so come what may. We look forward to continuing

to partner with government and key stakeholders to forge solutions. I thank your committees for your attention to this important topic; we are happy to answer any questions you may have.

Written Testimony

of

The New York City Department of Health and Mental Hygiene

submitted digitally to the

New York City Council Committee on Mental Health, Disabilities and Addiction and Committee on Hospitals

on

Intro 2141-2020

December 3, 2021
New York, NY

Thank you, Chairs Louis and Rivera, and members of the City Council committees on Mental Health, Disabilities and Addiction, and Hospitals, for the opportunity to provide testimony on proposed introduction 2141.

The NYC Health Department supports intro 2141, which seeks to remove the term “mental retardation” (or the “r-word”) and replace it with the term “intellectual disability” in the New York city charter and administrative code. This much-needed change reflects the growing global awareness that individuals with intellectual and developmental disabilities (I/DD) have faced longstanding discrimination, stigma, and prejudice. Legislatively changing highly pejorative but ubiquitous labels for individuals with the terms intellectual and developmental disabilities is a first step to reducing this discrimination, stigma, and prejudice.

A 2010 study published in *Intellectual and Developmental Disabilities*, for instance, found that among American youth between the ages of 8 and 18 years of age in the United States, 92% of individuals had heard use of the “r-word” use pejoratively. Thus, intro 2141 is an important step forward as it seeks to correct antiquated and pejorative terms for individuals with I/DD.

We thank the Council for making this important change, and for your partnership in promoting the health and well-being of all New Yorkers.

New York City Council

Committee on Mental Health, Disabilities and Addiction

Committee on Hospitals

Hearing Testimony:

Access to Mental Health Services in New York City Hospitals

Alison Burke, Vice President

GREATER NEW YORK HOSPITAL ASSOCIATION

Introduction

Chair Louis, Chair Rivera, and members of the Committee on Mental Health, Disabilities and Addiction and the Committee on Hospitals, my name is Alison Burke, Vice President for Regulatory and Professional Affairs at the Greater New York Hospital Association (GNYHA) and its point person on behavioral health issues. GNYHA's voluntary and public member hospitals are strongly committed to providing the highest quality behavioral health care to all individuals in need throughout New York City (NYC) and New York State (NYS). Today I will discuss how hospitals deliver behavioral health services amid the ongoing COVID-19 pandemic and longer-term plans to continue to transition services to outpatient and community-based care.

Behavioral Health Services During the COVID-19 Pandemic

New York's hospitals have been at the forefront of the COVID-19 pandemic for nearly two years. Preserving hospital capacity has been paramount throughout the pandemic. While COVID-19 vaccines are our most effective tool to prevent hospitalizations, the potential emergence of vaccine-resistant variants of the virus could rapidly strain hospital capacity. Hospitals therefore continue to operate under constantly changing conditions and stand ready to "surge and flex," which includes cancelling elective surgeries, adding beds, and moving staff and patients as needed.

Despite COVID-19's ongoing challenges, hospitals have continued to provide essential behavioral health services. At the beginning of the pandemic, hospitals acted swiftly with the City, the State, and community-based partners to coordinate consumer need and system capacity. Hospitals and their ambulatory networks quickly pivoted operations to maintain access and continuity of care. Hospital outpatient, inpatient, and emergency behavioral health services were operational and remain so despite the most daunting public health emergency in our lifetime.

Behavioral health capacity shifted across NYC and *throughout the State* in response to COVID-19. Hospitals and hospital systems with behavioral health expertise accepted individuals who required inpatient behavioral health care to free up the necessary staff and equipment to care for the overwhelming number of seriously ill COVID-19 patients.

GNYHA worked immediately with the NYS Office of Mental Health (OMH) to facilitate transfers of individuals to OMH-operated State psychiatric centers when appropriate to maintain acute care

access. Lifesaving medication and care for individuals with substance use disorders was addressed in coordination with NYC and the NYS Office of Addiction Supports and Services (OASAS).

To "bend the curve" early in the pandemic, GNYHA worked with the NYC Department of Homeless Services and the NYC Health + Hospitals (H+H) Take Care isolation hotel program to house individuals requiring isolation and supportive services, including behavioral health supports.

Hospitals and partners streamlined and expedited referral processes and remained in constant communication to ensure successful transitions. Hospitals expanded the use of telehealth services, which remain highly utilized and preferred by many patients. Expanded telehealth services have reduced no-show rates and been positively received by patients and providers. The State also removed regulatory barriers to providing telehealth services while ensuring quality, such as expediting the provider approval process, removing spoke and hub locations previously required of patients and providers, and permitted telephonic-only services. These efficiencies facilitate hospitals' ability to serve more individuals in a timely manner. Hospitals also maintain the ability to provide in-person care for those who need it most.

While the pandemic continues, we have not lost sight of the need to address the ongoing opioid epidemic. GNYHA supported approximately a dozen NYC hospital emergency departments' efforts in highly impacted communities to improve access to evidenced-based medications for individuals identified with opioid use disorder and connecting them to ongoing community-based care.

None of this would have been possible without health care workers' tireless efforts across the City and State. GNYHA and our member hospitals have therefore also focused on providing behavioral health support for the hospital workforce. GNYHA's Clinician Wellbeing Advisory Group (CWAG), a diverse group of health care leaders from our member hospitals, has met regularly since April 2020, with an emphasis on supporting the workforce during and after the COVID-19 crisis. CWAG is committed to advancing clinician wellness and resilience through collaboration, information sharing, and advocacy regionally and nationally. In recent months, CWAG has been developing a program that supports institution-to-institution mentoring focused on health and wellbeing components that address clinician burnout, and a resource network for clinicians to seek behavioral health services outside of their own institutions. While many institutions have invested in providing behavioral health services for employees, stigma, lack of convenience, and fear of consequences often present

barriers to seeking treatment. We hope that this resource network will help overcome these barriers and further promote wellness.

GNYHA also partnered with the US Department of Defense, Uniformed Services University of Health Sciences, US Department of Veterans Affairs, H + H, the New York City Department of Health and Mental Hygiene, and the Fire Department of the City of New York to develop the Healing, Education, Resilience & Opportunity for New York's Frontline Workers (HERO-NY). This five-part "train the trainer" series relies on military expertise to address trauma, stress, resilience, and wellness. It was adapted for a civilian audience to support the mental health and wellbeing of frontline workers affected by the COVID-19 pandemic. It has also been shared with numerous City agencies and is publicly available on GNYHA's website.

The Shift from Institutional to Community-Based Care

New York hospitals are committed to maintaining sufficient behavioral health capacity. While there is concern about proposed changes to hospital services—as there always are—these changes reflect a necessary and positive shift away from inpatient care and towards outpatient and community-based care. Local, State, and Federal policy priorities have long focused on improving the patient care experience, improving population health, and reducing the cost of care.

Inpatient care should be neither the first point of access nor the routinely relied upon level of care for the overwhelming majority of patients. Non-institutional settings allow them to stay in their communities and homes with their families and support networks. Outpatient services of various intensities (e.g., clinic, intensive outpatient, and partial hospital programs) provided before a crisis or emergency is always preferred. This is accomplished through strong partnerships with community-based organizations. Reforms made by the NYS Medicaid Redesign Team and implemented through the Delivery System Reform Incentive Payment program facilitated significant opportunities for system transformation and improved clinical and population health with a focus on behavioral health services.

There will always be a need for robust inpatient behavioral health hospital services, but care delivery is changing, and ambulatory and other community-based services are a significant component of this change. Any examination of behavioral health service utilization in NYC must account for this trend and include ambulatory care data alongside inpatient data to get a true picture of the available

services that New Yorkers utilize.

Hospitals have invested a great deal in ambulatory psychiatric care, but they can ultimately only control what happens within their own four walls. Engaging in community-based care and with community-based organizations allows providers to meet people where they live and address social determinants of health.

Behavioral health services also suffer from woefully inadequate Medicaid reimbursement. In 2019, Medicaid reimbursed only 64% of the cost of inpatient psychiatric care services. Commercially insured patients only represent about 25% of total revenue for these services, meaning public programs such as Medicaid are critical to ensuring that behavioral health services are available for all patients. GNYHA consistently advocates in Albany for higher Medicaid reimbursement rates and investments in behavioral health services.

Conclusion

Despite the ongoing COVID-19 pandemic, hospitals across New York are committed to maintaining robust behavioral health capacity while they invest more broadly in outpatient and community-based care. GNYHA's member hospitals are dedicated to providing the best possible behavioral health care at a time when they are most needed. Thank you for the opportunity to testify on this important issue. I am happy to answer any questions you may have.

Joint General Oversight Hearing on
Access to Mental Health Services in New York City Hospitals
December 3, 2021

Introduction and thanks:
My name is Brian Moriarty, and I am the Assistant Vice President of Behavioral Health & Senior Housing Program Services Department Services at Volunteers of America-Greater New York. We are the local affiliate of the national organization, Volunteers of America, Inc. (VOA). I would like to thank the Chair of the City Council Committee on Hospitals, Council Member Carlina Rivera, and the Chair of the Committee on Mental Health, Disabilities & Addiction, Council Member Farah N. Louis, for the opportunity to submit my testimony.

About Us:
VOA-Greater New York is an anti-poverty organization that aims to end homelessness in Greater New York by 2050. As one of the largest providers of services to families and individuals experiencing homelessness in the Greater New York area, we deliver services to more than 11,000 adults and children annually through 66 programs in NYC, Northern New Jersey, and Westchester.

These include four shelters that offer a range of on-site services for residents who experience persistent mental and behavioral health issues, including frequent hospitalizations, serious physical health diagnoses, and substance use issues. At the Wales Ave. Residence and Creston Ave. Residence, we provide comprehensive services to adults and young adults with persistent behavior health issues. We also operate scattered site apartments across the Bronx for chronically homeless single adults with substance abuse disorders, serious and persistent mental illnesses, and/or live with HIV/AIDS.

We thank the Council for their support of our programs. And we speak from experience when we discuss Access to Mental Health Services in NYC Hospitals because we work at the forefront of this issue day in and day out.

Key recommendation:
Here is the key recommendation we would like the members of this Committee to take away from our testimony.

The time has come to stop using “Call 911” as the answer to our every mental health-related request, though this is precisely what “Call 911” has become, especially as COVID has amped demand while drawing down services. This rotating door, whereby clients’ behavior is too often and too quickly deemed to be substance induced and unrelated to serious mental illness is abetted by the fact that under the current system there is no communication between electronic records in various institutions, meaning that clients can be seen in multiple hospitals and let out each time.

This has led to a system that is reliant on treating and releasing, or “Treating and streeting” as we call it. But “Treating and streeting” clients rather than holding them long enough for adequate

evaluation and stabilization does not address the needs of the person decompensating. Releasing them well before they are stable enough to be discharged puts both them and their communities at serious risk of further harm.

The current mental health crisis is a public health issue and needs to be treated as such. Lack of access to a comprehensive and responsive mental health system impacts entire communities, subjecting families to long lasting trauma, resulting in high costs and leading to the over-utilization of city hospital system, shelter use, and law enforcement resources.

While we are grateful for the Council's efforts to increase funding for mental health in FY22, this momentum must continue. VOA calls on the Council to prioritize and baseline additional mental health programming funding for organizations like us to continue to do this important work in FY23 and beyond.

In addition, we ask the Council to be our partner in addressing the major systemwide mental health workforce crises. The City anticipates a shortage of 250K social workers over next 5 years. This workforce issue is a widespread issue with enormous ramifications that can be proactively addressed with equitable funding to achieve salary parity, COLA increases, and indirect cost rates.

Finally, we note that individuals also deserve to be taken care of beyond the point of release. We must invest in long term care.

Closing and thanks:
On behalf of VOA-Greater New York, I would like to thank the Committee on Hospitals, and the Committee on Mental Health, Disabilities & Addiction, Council Member Farah N. Louis, for providing us with a platform to discuss access to mental health services in New York City hospitals. We are grateful for the leadership of Chairs Rivera and Louis and look forward to partnering with you both as you advocate for people with mental and behavioral health issues and intellectual disabilities.

Respectfully submitted by:
Volunteers of America - Greater New York
135 West 50th Street, 9th Floor
New York, NY 10020

Testimony of Lillie Cariño Higgins, Director, 1199 SEIU,
before the New York City Council Committee on Hospitals jointly with
the Committee on Mental Health, Disabilities and Addictions
December 3, 2021

Good morning, Speaker Corey Johnson, Chairpersons Carlina Rivera, Farah Louis, and all members of these committees. Thank you for this opportunity to speak on behalf the 6,000 members 1199 represents working in federally qualified health centers, in community-based organizations, and in correctional health. They are front line workers providing much needed essential mental health and addiction services in difficult times, under challenging circumstances. These workers are dedicated. They work in high-risk settings, at times becoming victims of assault. Their wages are extremely low, and I am here to urge you to correct this unjust imbalance.

Historically, community-based behavioral health care providers have had difficulty with workforce recruitment and retention. Their services are undervalued and underfunded. The workers are not viewed as healthcare professionals despite meeting the same educational, licensure, and certification credentials required of their counterparts in other sectors. Their qualifications are not reflected in the low wages their employers can offer; wages that remain low simply because the reimbursement rate for their services remains ridiculously low. These members work two jobs just to meet financial burdens to support, feed and house their families, repay student loans and meet their other obligations.

Community-based clinics provide essential services to clients within their own communities, reducing the need for more expensive hospital or residential settings. This became evident during the COVID pandemic when these clinics became the lifeline to many. Access to our overburdened hospital systems was both limited and feared. These clinics became the only option for many homeless mentally ill clients who are difficult to track and treat, clients known to be resistant to care. Our members worked day and night, despite staffing shortages and high risks, to provide quality care, at times lacking proper PPEs themselves.

Mental health diagnoses can range from mild to acute, and oftentimes the clients present multiple symptoms, requiring more complex treatment plans. Opioid and other substance or chemical addictions require more comprehensive care and treatment planning. Absent continuity of care, individuals tend to stop medication, decompensate, becoming disorientated and/or violent resulting in hospitalizations or incarceration.

Increased caseloads due to COVID demands, low wages due to low reimbursement rates, and ongoing staffing shortages result in the need for double shifts and burn out. For community-based health care to survive, there must be a commitment to better invest in these services and allow providers to offer workers wages comparable to those provided by hospitals and other sectors. Salaries earned by social workers in a community-based clinic are much lower than those earned by social workers in the same titles with the same qualifications working in hospital settings. The need for parity is clear as those agencies continually lose workers to the higher paying institutions. Shortages also place an unwarranted burden on our hospitals.

Community-based clinics strive to serve their communities with the language proficiency and cultural competence necessary to optimize communication and care, enabling them to gain the trust of clients. They usually are the primary care provider for entire families allowing for a holistic approach to treatment planning that includes education and guidance with clients and their families, thereby decreasing the stigma that comes with mental illness.

Recruitment and retention are key for community-based services to thrive and will only be achieved with wage parity with other sectors. This is vital work. These workers deserve to be treated as valued health care professionals.

Again, thank you for this opportunity to discuss our concerns.

Testimony of Dreana Bellamy, Organizer, 1199 SEIU-UHWE

Good Morning City Council Members

Thank you for meeting with us today we appreciate your efforts to improve behavioral health services. My name is Dreana Bellamy I am an 1199 Union Organizer at The Bridge. The Members that work at The Bridge are frontline behavioral healthcare givers

These Members work every day around the clock with a very challenging population to provide direct mental health services and coordinate medical and other services for The Bridge clients.

The issues that these Bridge staff face in this challenging work force, is Low pay. This is the primary challenge to both keeping current and attracting new behavioral health care workers which prevents patients from accessing needed behavioral health care services.

Often Staff with Bachelors and Master Degrees are currently earning $25k -$35k per year for this very challenging work. This is not sustainable and we will continue to lose staff as wages in many low skilled jobs such as i.e McDonald's, Starbucks, Amazon meet or exceed these salaries for this critical work. State and Federal agencies need to increase the level of wages and provide a cost of living increase yearly.

When the City Council considers policy proposal to improve behavioral health services, it is important to remember that the frontline caregivers are critical to both of the quality and access to care, and much of what needs to improve the working conditions of those providing care.

Thank You for listening.

Testimony of Cherray Mathis, The Bridge

Good morning. My name is Cherray Mathis. My desire to help others in my community is innate. I currently serve my community as a care manager at a nonprofit mental health and housing solutions organization. I feel proud and fulfilled working as a care manager! I assist the most vulnerable individuals in our community as they effect short- and long-term change in their lives and wellness.

Throughout the COVID-19 pandemic I have juggled being a full-time graduate student, full-time care manager, and per-diem residential counselor working overnight shifts. I look and am every bit the part of a dedicated and selfless social service essential worker. My community counts on me to expertly balance working two jobs and continue going to school.

But let's be transparent! Maintaining two jobs and going to school is not just me giving the altruistic performance of a lifetime, it is a must! My current salary as a care manager does not support the financial burdens I have to bear. Furthermore, the shortage in the workforce (due to high rates burnout and turnover of individuals leaving for better/higher paying fields) means that I am desperately needed to assist with shift coverage in 24-hour supported housing programs. Dropping out of school personally affects me by jeopardizing long term salary gains and dimming career outlook. For my community, abandoning my educational advancement once again stresses the social services workforce shortage.

During the pandemic I reflectively began to wonder where does this mindset of social service workers not deserving to make a living wage come from? When I talk to my peers, we all want to make living wage. We have hopes and dreams, we want financial stability and on a daily basis we would like to adequately self-care to avoid burnout! I care deeply about my community; I would like to – no – need to see the narrative of social services being a thankless and underpaid profession change!

In the future, my community can count on me to become a licensed clinical social worker and wellness life coach. I am asking to count on you to increase the funding needed to support living wages for social service essential workers.

Thank you.

Cherray Mathis
Care Manager, Pathway Home OMH
The Bridge

10/17/21

Allen Mena

Public Health Advocacy

Addressing the High Cost of Baby Formula in New York State

Malnutrition is a huge issue for lower income families of all ages. However, one specific issue that must be addressed is malnutrition for infants whose mothers are unable to breastfeed them. This malnutrition leads to a variety of diseases not being treated, and some examples include, but are not limited to, gastrointestinal issues, Crohn's Disease, etc (S3386). The reason for the issue at hand is the high price of infant and baby formulas and a lack of legislation regarding it. Mothers do not have insurance coverage currently in New York State that covers medically-necessary baby formula, and this has led to a number of studies providing important data on the topic.

The reason why this issue has not been dealt with already is because of a variety of misconceptions about breastfeeding, and mothers' ability to breastfeed in modern society for a long period of time (~6 months). Some mothers cannot simply choose to breastfeed their children because they belong to lower-income families where mothers are expected to return to work, and the "timing of the return to work and quitting breastfeeding will coincide." (Kimbro, 2006). Therefore, Women working in manual and administrative occupations can cause significant health implications for their infants by quitting breastfeeding earlier than 6-12 months, like the diseases mentioned previously (Kimbro, 2006).

Another obstacle blocking women from feeding their infants with breastfeeding as an inexpensive alternative to formula is the difficulty of breastfeeding. Many mothers are not well-educated or trained on the topic of breastfeeding, and it is no coincidence that this concern was

even higher among minority mothers and mothers with an annual household income below the poverty level (Ruowei, 2008).

These issues can be alleviated with a policy change on insurance coverage regarding medically-necessary baby formula. The proposed policy's primary objective is to ensure that every policy that provides coverage for prescription drugs will also provide coverage for the cost of enteral (meaning orally or administered via G-tube), infant and baby formula, under a prescription order from a doctor (S3386). The other goal of the policy will be to address the issues facing lower-income families and their ability to provide nutrition for infants.

Some direct impacts of the bill that will help legislators and lawmakers reach the desired result are increased access to nutrition for lower-income communities via insurance and prescription coverage for mothers and it mandates that insurers in New York State cover infant formula for an amount no less than three thousand dollars in a 12-month calendar period, which guarantees that the cost of the formula will be drastically reduced or covered in full (S3386).

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Testimony of Kimberly Sylvester, The Bridge

Good morning,

My name is Kimberly Sylvester. I work for The Bridge Mental Health and Housing Solutions. Funding for programs like the one I work in is crucial for recruiting and retaining staff. Too many times a single mental health worker is left to cover any entire facility alone.

We watch over sex offenders, murderers, the mentally ill and the developmentally disabled. Many of our clients are unmedicated, have substance abuse issues and are extremely violent. Yet, we are left to oversee buildings with as many as 60 clients alone and many workers are only getting paid minimum wage to do so.

Due to the staffing issues created by low wages, current staff have been forced to work double and sometimes triple shifts. Many workers need to have two and sometimes even three jobs, just to survive. These programs are not sustainable without funding for staff.

We work in unsafe and unsanitary conditions. We are also the first and last line of defense who sound the alarm before these clients enter the community. Too many times, workers are beaten so severely they require medical treatment and several months of recovery for injuries sustained.

It's a lot to ask of us for such low wages. So, I am here today to ask for funding specifically for livable wages.

Thank you.