

October 2021

OMH Statewide Town Hall

Transcript



Office of
Mental Health

FINISHED FILE

OMH
OCTOBER 28, 2021
12:45 P.M. CST

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>> This meeting is being recorded.

>> BEN ROSEN: Good afternoon, everyone. I'm Ben Rosen Director of Planning for New York State Office of Mental Health. Welcome to the OMH statewide town hall. Today we have a number of presenters, Commissioner Ann Sullivan, Emil Slane, Thomas Smith, Christopher Smith, and Denise Balzer, Director of Crisis Services. From 2:00 to 3:00, we'll be doing presentations or thereabouts, and from 3:00 to 4:00 we'll be taking public remarks and testimony as well as doing some Q&A. Thank you for joining us.

So, just before we get started, participants wishing to speak must select the hand-raise button located on the right side of their screen. Once we get to that public comment period today, participants with their hand raised will be announced and then muted as time allows. We're asking people to limit their spoken comments to 3 minutes. Questions and comments will also be taken in the chat box by directing comments to All Panelists. We'll also accept submission of

additional comments through November 12, 2021 at transportation@OMH.ny.gov and we'll provide that link after the meeting as well.

A few housekeeping items. This meeting is closed captioned in multiple languages. The multimedia viewer should be located in the lower right-hand side of your screen and to view captions in your multimedia viewer, select Continue adds illustrated in the image on the right. Each participant can customize the font size, color, and background color for captions and these adjustments aren't seen by any other participants.

We also have two American Sign Language interpreters. OMH Cheryl and Megan. They're panelists and they'll be alternating interpretation responsibilities during the presentation. If you require these services, please lock your videos -- lock their videos to your screen. Right click on each of their video thumbnails, the little circle in the corner, and select move to stage and that will allow you to see them during the presentation.

This event is being recorded. It's also being transcribed and we'll make the recording, transcript, and presentation slides available on the OMH website shortly after the event.

So, with that we thank you, and I'm going to turn it over to OMH Commissioner, Dr. Ann Sullivan.

>> ANN SULLIVAN: Thank you, Ben. Welcome to all of you for joining us today. I would like to start first by thanking everyone for what you have done over the past, I guess it's almost 20 plus months now since the start of this pandemic. It has been a difficult, challenging journey for all of us, but I think the mental health field, all of you and all of everyone from OMH that I work with, have just been terrific. I can't say enough about how the mental health system has responded to the needs of New Yorkers. You've been dedicated, you've been committed, despite I know many losses in families and friends, and many of the challenges that we all faced personally, you've all been there for our clients and those we serve, so thank you. I can't thank you enough.

We're going forward now into a new phase. I think this is not over yet. I know that now we're all facing a combination of a little bit of relief because of the vaccine being there, but also the challenge of helping everyone to get vaccinated. So, again, just to say that we are there to work with you, that the partnership will continue.

What I'm going to be talking about first is kind of an overview of some of the key things that have impacted us during the pandemic, and then you're going to be hearing from staff about more of this in detail, and also about some of the

funding which has flowed, especially from the federal government, to help behavioral health issues across the country and certainly in New York State as well.

So, first of all, I would just like to talk a little bit about some of the things in general that we have been dealing with. So, Ben, go to the next slide. We all know these numbers, but it's important I think to keep saying them because anywhere from 40-50% of New Yorkers will be impacted with mental health issues as a result of the pandemic. That is a strain on all of us in terms of access and making sure that we can serve those New Yorkers, many of whom have never touched the mental health system before. That is something which we have not experienced to this magnitude on a state level and something which I'll be talking about how we're trying to address that issue.

The other number which is really the most tragic, I think in some ways, is that statement on the bottom from the United Hospital Fund study that said that 4200 youth lost a primary parent or caretaker as of July of 2020, and we know that that number is probably considerably higher now. That's an impact that will go on for generations and for decades, and so we have to be here to remember that the impact of this pandemic, even after it hopefully becomes less severe and slows down and maybe has been more and more back to normal, but the impact of what we've all been through will continue, and we have to have the services ready to deal with that. Next slide.

The other key issue which the pandemic pointed out to us in stark detail is the degree of health care disparities that our health care systems carry with us each and every day. And if you look at the mortality data, and I won't go through this, but this is mortality data as of August of 2021, and you can see that our minority Black and Hispanic community it's were hit much harder than our White communities and that's something that we, I think, all have to take some responsibility for as members of the health care system. We have not had equal access to care and that's probably going to add up to some of these tremendous disparities that we saw in terms of morbidity and mortality. That's something else that we have to address and something else that's been brought to all of us very clearly through this pandemic. Next.

Okay. Now, just to talk about those disparities for a minute. There is a lot that we're doing with the Office of Mental Health. I know some of you are involved in a variety of seminars and webinars we've had about how to look at ourselves, look at our agencies, take a look at how we can address -- we can't solve everything, but there are things within our system that we can address. We're going to continue to work on this

and we'll continue to have learning communities and collaboratives on working on reducing disparities.

One of the big ways that I think to have an impact here is to look at data, to look at the data that we usually look at, things like engagement, things like whether or not patients have easy access to care, things like individuals are getting hospitalized or not, what kind of treatment they're getting. But to break that data down by race and ethnicity, and then look at it and look at ourselves in a critical and honest way as to whether we're providing equal services across our communities.

So, for example, thinking about our state system for a minute and the fact that we've had a major initiative on Clozapine and we don't know, to tell you the truth, we don't know whether or not we've been successful in Black and Brown communities and Hispanic communities in utilizing it for treatment in schizophrenia as we have been in White communities and we don't know that and we're going to get that data. We need to come up with a data dashboard which we're going to pilot first in the Office of Mental Health, and that will include things like whether or not individuals are getting primary care, getting appropriate primary care, whether or not they're getting access to care, are they staying in treatment, are they engaged, and breaking that down so we can look and see if we're doing the right thing across multiple racial and ethnic groups.

And then after we piloted it and got it kind of right, we hope, within the state system, we would like to use a similar way to look at disparities across the whole system of care. You'll be hearing about that. There have been a number of people that spoke to this and said that if you're going to have an impact, you really need to have the data and then monitor whether or not whatever you're doing differently is having an impact in the community, so we'll be working with all of you on these issues. Next.

The other thing I want to mention is something that we launched with the FEMA dollars. We got a large FEMA grant for prevention, prevention of the long-term part of the impact of this pandemic, and I think all of you know about Project HOPE. It's successful in reaching over 100,000 New Yorkers in terms of crisis counseling and group crisis counseling. A lot of group work has been done virtually, some of it in person, and some of the crisis counseling virtually and in person. We've been using a hybrid of those services, but the important thing here is that many, many of the individuals contacting Project HOPE never had mental health contact before. In some ways that's good news, but the stigma of asking for help is less,

but what's the concerning and challenging news is that we know we have to be there for these individuals as time goes on, so Project HOPE has had crisis counseling, both group and individual, and also has a wonderful website and if you haven't seen it, tune in and look. There is a tremendous amounts of materials that we put out. In you go to the next slide, some of the numbers show that we've contacted with individual and group contacts for crisis counseling up to 165,000 New Yorkers.

The other interesting thing, going back to what I side previously about diversity. When we first looked at the data, because Project HOPE is consolidated and you can look at the data, but we realized the individuals calling the help line were primary White and we were not reaching through the help line the communities that we needed to reach. We then did a lot of grassroots outreach to community-based on-the-ground individuals in the Hispanic communities across the state and if you look at the bottom, the community outreach has definitely worked and we've been able to have a large impact on Black and Hispanic communities. Again, data helps inform how you look, how you outreach, how you pivot to make sure that you're getting to the most needed communities. Next slide.

The other thing which we all know, and I think we've all been kind of excited about, there has been a rapid shift to telehealth, and we know that prior to this pandemic, about 2% to 3% of all contacts for telehealth in February to -- or by April of last year, in April it was about 90%, and now we're in a range of about 65-70% on average and we're getting more data. The interesting thing here is how quickly -- and congratulations to all of you because everything pivoted to something that enabled us as a system of care to provide services through this pandemic. And, really, kudos to everyone that participated in making this happen. It's also taught us, I think, how helpful technology can be. So going into the future, technology is something that we want to get increasingly creative about, and I think probably we're going to end up with a hybrid, somewhere in the range of some work being done, much more by telehealth but also continue the important in-person work and maybe even a hybrid. I talked to a couple of providers who have already had groups that are half telehealth and half in person by using all the safety guidelines and distancing, but it makes it easier for some individuals that maybe couldn't get there that day to tune in on telehealth. So, our creativity in using this incredible new tool, it will be great. Next slide.

What we've done is worked very hard to make sure that the ability to get paid for this continues post the pandemic. So, in Medicaid we're pretty confident pretty much everything that

we've been doing throughout the pandemic will continue. On Medicare, we still need some lobbying to make that happen. Now the current and most recent Medicare guidelines still talk to having certain interim face-to-face things being required for individuals with telephonic care so I think we still need lobbying here to make sure basically both under Medicaid and Medicare and commercial insurers, et cetera, that we have the wide range of ability to use these new tools because we know they've been effective throughout the system, and we also know, we did surveys with clients, and they even found it very helpful, very useful. There is preferred in-person care and we have to recognize that and we have to respect that. But we have found that basically a lot of people have adapted to this and really value it, and it has as all of you know decreased the no-show rates across the system which is impressive. Next slide.

Just again to mention vaccines. We are here to help with any vaccines you need. Again, we can still do mobile outreach if you need it. We are there to help if you need it. We've been very successful across the system of care both for our clients and for many of the other individuals throughout OASAS, OPWDD, OTDA and in general over 78,000 doses of vaccine across the state and I can't thank my OMH staff enough for doing this on top of everything else they were doing, went full steam ahead to help get vaccinations out there into the community. Next.

Just the other big lesson we ran into here and you're going to hear a lot about it so I won't talk too much about it. We need to look at our system of care. One of the big things here is that we get the appropriate level of crisis services, we'll go through a whole presentation on crisis services, and also that we integrate care, and also that we expanded our behavioral health centers so that we have more and more ability to have comprehensive, integrated clinic services as well as crisis services. Next slide.

Next, Ben. Are we stuck?

>> BEN ROSEN: Should have advanced. Try it again.

>> ANN SULLIVAN: Okay. So, the certified community behavioral health clinics. This is exciting. Money is coming from the feds to expand these further and including several -- we have our original 13 but now there are multiples of those across the state. Next slide.

The crisis services you're going to hear a lot about, but the main thing here is we all have to work together to make sure that that 988 number and connection to the crisis services work. I believe this is a game changer for the state and nation. Individuals should have an easy number to say I'm in a

big crisis or little crisis, whatever is going on, I can call and get help easily and I don't have to fumble through pages, I don't have to try to find a number, and I can really connect to what I need and get that immediate access, and that's what 988 is all about. Also, about some police diversion, et cetera, but really there to make sure people have easy and rapid access. Next slide.

So, in response to everything that we're doing or going to do, we're going increasing prevention in OMH and you know there have been a lot of people that looked at prevention in mental health and recognized that we have not been as robust as some other, the rest of medicine in some ways in prevention. We're going to be growing our prevention office but also going to be continuing to expand all the prevention services, and we're going to be talking about this more at the end of the presentation, so I won't go into it now. But certainly, it involves schools and it involves primary care and it involves us thinking about our clinics getting also more involved in prevention relative to social determinants.

Next slide. Finally from my piece, but this is going to be talked about in more depth by Emil. We need to strengthen the behavioral health workforce. There have been dollars that have come from the feds and Emil is going to go into this in detail where we can hopefully be more successful in recruiting and retaining individuals into the workforce by using some of these dollars as retention bonuses, as educational enhancements for tuition, et cetera. So, Emil is going to talk about this in detail, but there is a lump sum of money of 37 million dollars coming out to the workforce and we're very excited about this and I think if we do this right, it can have a real impact because we know how much we're all suffering from not being able to recruit the numbers that we need into our workforce. Next slide.

Ben, next.

>> BEN ROSEN: Should be advancing.

>> ANN SULLIVAN: Okay. And then the other thing, and this we need lots of advice from you as well. We're going to be expanding collaborations with schools to enable professional schools to enable us to get more individuals into the workforce. We're going to be thinking about suing stipends, ways for them to get experience in the mental health field, so those expansions should be across the state and various localities connected to universities and working on that. We're thinking of establishing a community mental health worker title that could be someone to work so that our professionally licensed people can work to the full license. This is something that we've done certainly on the medical side with

nurse practitioners and physician assistants and maybe we need to do a bit more of this in some of our other professions so with the workforce knowing that we will never probably have a sufficient workforce, then how do we extend the talent of individuals by bringing others into the workforce and people from the community who can work with the community. So, we'll be discussing this all with you and seeing what might be possible. And I think that's the last of my slides. Ben, yeah, so now I'm going to turn it over to Dr. Smith and then Emil and then Chris Smith to talk about some of the things that I mentioned in more detail. So, I'll turn it over now to you, Tom. Thanks.

>> THOMAS SMITH: Hi, Ann. Can you hear me?

>> BEN ROSEN: Yes, we can.

>> THOMAS SMITH: Thanks, Ben. Hi, everybody. I get to talk about COVID, which in some parts is at the front of everybody's mind as always, but we all can't wait until it's in the back of our minds, but not quite there. Maybe in the next several months we'll get there. As Ann said, it's been quite a ride, you know, the past year and a half. We thought back in March or April, we thought we might be facing a difficult summer. Nobody thought it would be a year and a half. Some people did, but most did not. We really as everybody knows, we had to scramble right away in early 2020 to reconfigure immediately the in-patient behavioral health services in the state but also in New York City. Also, the ambulatory and clinical services. Residential programs took a lot of stress and strain over last summer. We all remember that we were probably most worried about some housing and residential programs that didn't have a lot of the supports or access to PPE that the hospitals might have had, so it was a very difficult summer for them.

We do think that we came through the first surge last summer with the public mental health system intact. We essentially integrated the psychiatric hospital in-patient system across the state, you know, the public hospital system in New York City, the state-operated psychiatric centers, and the community hospitals all worked together to shuffle around beds and make sure that everybody who needed acute care got it. As everybody knows, we rapidly shifted over to telehealth on the ambulatory side. We mobilized some of our act and mobile crisis teams to help with care transitions for people coming out of hospitals. There was a lot that was done last summer that got us through that first surge, and that was despite as it says on the slide, the staffing shortage that has only gotten worse since then.

So, a lot was done. Can we go to the next slide? We've

issued infection control guidance for both the state-operated system and the community ambulatory system that's been updated regularly. I think our last update was just about 10 days ago to incorporate some of the ongoing changes in guidelines for infection control, vaccines, et cetera. So, for those of you who haven't visited yet, go to the OMH website. We've got a page on guidance documents there. We have a separate page that's all COVID related, again, with a lot of guidance whether you're an ambulatory provider, a consumer, or a hospital provider. We've got a lot up there to help you out. If there are things that -- if there is guidance that you think is missing or necessary, let us know. We see that as a key part of our role. Next slide.

On the state-operated side, so folks know, we have that OMH operates three psychiatric hospitals, the state hospitals, and on any given day they serve 3,000 to 4,000 people. In the past year and a half, about 11,000 people were served during the COVID surges and we had a total of three surges in New York State, so 11,000 people served. A fair number of them were exposed to COVID as we all were, so we had to rapidly implement infection control, PPE protocols, policies, distancing, et cetera, et cetera. A lot of work within that state-operated system, and we're proud that the system is still hung together very well. And not only has it hung together well, but it's really stepped up and we'll talk about it with our vaccination program. The state hospital system has played a major role as a member of the larger public health system in New York State over the past year. Next slide.

In one of the examples of that, the COVID-19 vaccination efforts. We very much wanted to make sure that our patients in the state hospitals would get vaccinated as soon as possible and our staff as well. These are hospitals like all other hospitals with health care providers, so we made a big push right away last October and November to get included in the first wave of vaccination programs for the state-operated hospitals, and we were able to do that. We did 8,000 or 9,000 vaccinations just in the first week or so of January of 2021. The agency program did so well, actually, that the Governor's Office asked if the state hospital vaccination program could help provide vaccinations to people outside of the behavioral health system, people in the shelter system, people in foster care, people in the OPWDD system, in housing programs that aren't able to make it to the pharmacies or their doctor's offices or hospitals. So, the state hospital system stepped up as Ann mentioned, and delivered almost 90,000 and we really think we'll hit the 100,000 mark in terms of vaccine administered by the state psychiatric center system throughout

New York State throughout 2021, so really a remarkable job of both maintaining the integrity and standards of care for these 23 psychiatric centers but also serving almost 100,000 New Yorkers outside of this system. Really remarkable. The OMH staff has done all sorts of work with videos, posters, brochures as noted there. Again, go to the website there and can you get access to a lot of this information, and if you're having a hard time finding it, let us know and we'll get it to you. Next slide.

Oh, this is just evidence of the impact of our testing and vaccination programs. It was last November and December where we implemented routine twice-weekly testing of all staff and patients in the psychiatric center state hospital system, and then that was right around December 1. Then right around January 1 is when we vaccinated 9,000 of our staff and patient, and can you see the curves. These are rates of COVID positive individuals. The highest occurred, the one that bumps up real fast is the patients in the psychiatric center hospitals, so you can see in that second surge that began in November of 2020, you can see the rates of people getting exposed to COVID in the hospitals shot up very high, much higher than the rate of the general population of New York, which is that bottom line. And then in the middle is the line of the rates of OMH staff getting exposed to COVID. So, you can see patients and staff workers in hospitals are much more vulnerable to getting COVID than the general population. It's understandable. These are hospitals. But just to get a sense of the impact of the infection control and vaccination programs, you can see December 1 we started doing routine testing, COVID testing of all patients and staff. And then immediately that led to a significant drop in the number of COVID cases, and in the patients, you see it comes dropping down there. Then also that middle line there, the dashed line for staff starts coming down, even though the New York State surge is going up from December to January that bottom line goes up, up, up. And we remember the worst of the surge was in January of this year.

And then the vaccination program started in January, and look at how the lines for the patients and staff went down close to zero. So don't let anybody argue that routine testing, surveillance, monitoring, and vaccinations don't work. They worked dramatically in our public behavioral health system. Next slide.

We do have -- so we're hopefully -- we had a little mini surge, but hopefully we're coming out of that this fall and our fingers are crossed that we'll be looking good with COVID. We have some new dollars coming from SAMHSA on the order of 2 to 3 million dollars we'll try to push out primarily to housing

providers. The housing providers across New York State really had the roughest time throughout COVID in terms of access to support PPE, et cetera. So, we're going to start making some announcements shortly about housing providers getting access to dollars to support testing and vaccination efforts, education efforts, et cetera. I think part of it is that we want to make some dollars available for peer -- for agencies to use peer-led teams to go into the community to support vaccination education activities in housing programs. So, look for some announcements in the very near future because those dollars are available to us now. Next.

Just a couple more slides. So, Ann talked about a lot of this. There is ongoing prevention activities related to COVID, the Project HOPE program, all the infection control practices, learning collaboratives, et cetera. So, there is a lot going on. Our suicide prevention center of New York has continued to grow throughout the COVID period, so we're very, very excited about the role that that center plays, so a lot still going on. Look to our website and let us know what questions you folks have, and then I'll finish. I think the last slide is the next one.

We're proud to say that the public mental health system of care survived the pandemic and continued to serve and has actually grown over the past 18 months. Our clinics and programs are open with a range of in-person and telehealth services, and we're very confident in the integrity and quality of those services being offered.

The residential providers had a real tough time, but they've hung in there and have also maintained the integrity of that system of care. We're looking to support them further as we just mentioned. The acute care system, the hospitals, there is still a lot of concerns with beds shifting, beds open, beds closing. The system is still transitioning -- that's not the right word -- it's still evolving but we feel comfortable we met the needs that have arisen through COVID. We're hopeful to come out, again my fingers are crossed, coming out of the pandemic, hopefully this last surge. We've learned a lot, done our best to protect the health and well-being of the people we serve, and we learned enough to really help us innovate and try some new things in the near future. I think that's it for me.

>> BEN ROSEN: Thank you, Tom. Next up is Emil.

>> EMIL SLANE: Good afternoon, everyone. We want to provide an update on the Federal funding and some of the fiscal resources that we have to strengthen the system, and as the Commissioner indicated, we'll talk about the workforce dollars which we're getting out in motion and notifying providers in October. So, next slide.

Just the basic overview. Our final budget that was put into place in April had resources from two primary Federal sources. One was an enhanced FMAP rate increase for home and community based and rehabilitation services for the April to March period of this year. The State is earning enhanced FMAP federal contribution for these services, and what was reflected was in the budget and these resources will be programmed into the areas that are earning the resources to expand further and make investments. We're very excited about that and I'll talk further.

The other major source of funds is the community mental health block grant and so in the two rounds of COVID relief that the Federal Government enacted, 9 Office of Mental Health received 126 million dollars in block grant supplemental increases that were programming across the next 4 years to strengthen the system, and so OMH did extensive stakeholder engagement, and we are posting updates to all of this work on a regular basis and still get substantial input to inform our work, but we did a planning process on the front end with substantial input from the field. We really appreciate your comments, expertise, and input. It's been instrumental in helping us to plan and start programming some of these funds. But all of these materials and information and input is located on our website. You'll notice in our slides, you know, we put links to many of these key documents that will give you high-level succinct summaries of the work that we're doing and how we're advancing this and the opportunities that will exist for community providers as we program these funds. Next slide.

So, I'll talk about the enhanced FMAP first. So, as I said, you know the state is earning an enhanced FMAP in a broad array of HCBS and rehab programs for a one-year period. OMH estimates that in our universe of reappear and HCBS programs, we could generate about 80 million dollars available for reinvestment. The New York State department of health submitted a plan to the federal government CMS for review that was submitted in July, and that plan is still pending formal review. You know, we received some positive feedback but also some questions in some areas, but we do anticipate approval in the coming weeks.

The spending plan is available on the DOH website. We have links to it on the OMH website. It's a 50-page document that really explains in detail all of the different proposals that could benefit the community mental health system. OMH has 11 different proposals linked to this funding source as well as several other proposals that were part of an inter-agency group where OMH is at the table designing and helping to roll out these dollars. Next slide.

I'll talk briefly about really four main areas that these enhanced FMAP dollars are going to be used for. And one is rate increases. So, we are preparing to implement rate increases for all of the OMH rehab services, including ACT, PROS, and Rehabilitation Services and CRs and those increases will be a minimum of 5% and they'll be continued in the out year so they'll be reoccurring. We also did federal public notices on these and we're preparing to submit the formal document state plans to move forward, and as those are reviewed and acted on and hopefully approved, there will be increases that will be paid out and posted for services starting in October. So those will be reoccurring investments for the field to help with workforce and to strengthen community-based services. In addition to the rate increases, there will be an adjustment to the rates that are for workforce investments, so we'll be talking about how we're investing some of the block grant dollars for workforce. The enhanced FMAP will have a workforce adjustment on a temporary basis paid to these programs, eligible programs, and those funds will be available for providers to pursue a wide range of strategies to help with workforce recruitment and retention and will be issuing guidelines on that. They're coming out this week, and those guidelines are intended to be flexible and to help providers use these resources to address their greatest challenges. Providers will be deciding those strategies and really targeting the funds for the best impact. But there is 16.5 million for the side also enhanced federal share. And in addition to the adjustments for the programs, we're also rolling out a peer initiative described in the plan for both fear and familiar support services and so I saw in the chat box, you know, one question was about workforce dollars to support expansion of peer services and recruitment and retention on the peer side, but we have a specialized program that's going to be coming out for providers that have currently employed peer or family support credentialed staff in their programs and/or are going to be hiring or helping people get peer and family support credentialing, training. We're going to be providing resources to enhance compensation, to help with retention, and to invest in that area. So, that will complement the other workforce recruitment and retention dollars, so we're very excited about that initiative and that will be coming out shortly, so keep checking our website.

In addition, we're working on an initiative to -- at the university level, and the Commissioner mentioned this, work with SUNY and CUNY to really help recruit at the front door and to help recruit clinicians in various disciplines to improve and help with cultural competence and workforce diversity, you

know, the community-based provider level. We have 4 million in our plan for that and we're engaging with SUNY and CUNY and very excited about that opportunity moving forward to help on the front door as well as many of the other strategies Commissioner Sullivan mentioned.

The other key elements of our plan include capacity building. We're very excited about that we received approval of the new core services, which are basically ensuring that people can get access to peer family support services without going through more extensive HCBS referrals and plans. They can get direct access, much more streamlined, and we're working to implement that and making investments into, you know, the CORE framework as we roll it out. We're excited about those services coming online and being able to get streamlined reimbursement and investing for startup in that area as those services expand, as well as implementing evidence-based practices in the adult and children's system, we have 4 million dollars to invest in helping providers implement evidence-based practices as well as an investment to assist the BHCCs in implement of alternative payment methodology, so we've worked to set up infrastructure with the BHCCs in partnership and we have final in the enhanced FMAP focused on outcomes but really to move forward into the alternative payment framework on the community-based side, so we're excited about that.

In addition to the workforce investments, rate adjustments, capacity building, there are other adjustments in the plan that OMH is start of the state inter-agency team and a key part is the children's services, including rate services to continue expansion of capacity, workforce and infrastructure investments. If you go to the next slide, Ben.

This is a chart in the presentation that lays out all of the elements that touch the OMH community-based system, and I mentioned, you know, the 11 proposals that we're working on that fall into the different categories that I mentioned. But this chart also includes the other areas in the DOH budgets that we're working directly with DOH on, so we're very excited about this 82 million in investments, and again, this is really the minimum. We think many of these we'll be able to leverage additional federal share and it will be a much greater investment than 82 million, but this will be a substantial infusion of investment into workforce and capacity building for community-based services as we come out of the pandemic. So, enhanced FMAP is a tremendous opportunity for rehab and HCBS and we're excited to keep expanding the services.

Next slide. The block grant is the other big source of funds that the OMH has in the federal relief bill. There were two bills. The original bill that passed, the coronavirus

response relief supplemental relief act allocated 46 million to OMH and we received that award, and then we received a second award of 80 million for the American Rescue Plan Act and those funds are alive for a two to four-year period so we have 126 million that we kicked off the planning process in the spring, and you know with stakeholder engagement. So, the key thing to understand with the federal funds is that they have to be used in accordance with the community mental health services block grant standards. So, they're required to be used for community services for adults with SMI, children with SED. They have certain set asides for children, services, first-step psychosis programs, crisis services, and they also can't be used for certain settings like in-patient, residential, capital, or provider losses. So, we went through an extension planning process, so if you go to the next slide, thank you. We went through an extensive planning process, and OMH had to submit an initial plan to SAMHSA which we received approval on and those documents are all on our website and we're working on implementing elements of this plan and each and every week, you know, more students come out. So, on our website, we have opportunities posted that many of you are applying for, and they'll continue to be opportunities there. In October the big focus has been rolling out the workforce money, so we've already notified providers in some areas of workforce recruitment and retention funds, and there will be notices going out for the 21 million that will be going to outpatient treatment programs, licensed by the Office of Mental Health, as well as community support programs that are eligible for these funds. So, notifications on that 21 million will go out shortly. It will go out tomorrow to providers, so and we'll be posting on our website the guidelines for the recruitment and retention funds so that your agencies can start to look at that. But more than 600 providers will receive funds really intended to be flexible to help with some of the workforce challenges.

If you can go to the next slide. This is kind of the same overview chart that you saw in the enhanced FMAP in the Federal plan. This chart is actually in some of our documents. It's in the October legislative report. It really has the blueprint and framework for all the priorities that, you know, our stakeholders have outlined and it's really broken into crisis services, children and youth and family, as well as ambulatory and peer services and workforce investments. So, we're -- this kind of gives you a blueprint of all of the major initiatives we're working on and as I said, the website as well as being in the grant's gateway to get announcements on OMH application opportunities, you'll continue to see these dollars roll out.

October has been, you know, the big focus has been on getting the workforce dollars moving. We know the challenge is there and that you need resources to address that challenge, and you know we're getting those funds in motion so that providers have assurance of what their allocations are and they understand how they could be used to help address those challenges. So next slide, Ben.

In addition to the Federal block-grant dollars and enhanced FMAP, in the final budget, OMH was able to proceed with the \$20 million investment for housing and we think that investment was so important. It brought our total investment to over 70 million in the last 5 years or, so and we've rolled out those investments and implemented them effective January 1. So those contracts are all in motion, and I know we've done sessions with all of the providers to ensure that they understand what's available and funds are starting to flow on that retroactive back to January 1 and so we're excited about those resources being available to the housing providers. And that, you know, we have in this round of investment, not just investments in unlicensed housing, but also the licensed housing which will get more investments and enhanced FMAP. Those investments included an increase for all supported housing programs, you know, either 500, 200, or 50 dollars driven by fair-market rent data and where they're located and the gaps that may exist for those programs, as well as investments for SPS or SP-SROs and upstream and included for apartment treatment and community residence and again it was effective to April 1 which we're implementing and the increases on average were 9% but a minimum of 5% for each provider as those were rolled out. Lastly, all of those were included in a compounding of the 1% that was in the budget that we implemented April 1. As we implemented the rate increases and investments in January, we applied the 1% to them in April to further enhance resources for housing programs. So those dollars should be rolling out in your contracts and start to be paid, you know, so that you can program it to preserve and ensure access to housing.

Next slide, please.

And lastly for our Article 28 partners and community partners, there is an opportunity that is out there that was announced at the end of September for the health care transportation funds Round 3. There is 208 million available to providers to help support health care transformation, and there are set asides for community-based providers and behavioral health services, so if you look at that program opportunity, I know we sent it around to our provider community on the listserves. But Article 28 general hospitals, including in-patient psych programs, Article 31, residential facilities,

Article 31 in-patient hospitals, Article 31 clinic treatment programs, all of these programs are eligible to apply for health care transformation funds, and it can include activities such as merger, consolidation, acquisition, other activities to help create financial and sustainable models, preserve or expand the essential capacity, and so we strongly encourage if you have a transformation work going on and resources could help, to help restructure the debt forgiveness or with capital resources to restructure, we strongly recommend that you consider applying for these funds, and the Department of Health will be working to award those in the coming weeks. Thank you. I think that covers all the slides and we'll turn it over to the crisis team.

>> BEN ROSEN: Thank you, Emil.

>> CHRISTOPHER SMITH: Good afternoon, I'm Chris Smith acting associate Commissioner for adult community care. I'm going to do a real quick overview and context about where we've been coming from with our crisis work and then turn it over to Denise to give you an update on where we're at right now.

So, we've had a real major focus on improving our crisis services in the community, starting with the carve-in to managed care back in 2015. So, since that time, we've added billing mechanisms to mobile crisis and crisis residences for both children and adults. For mobile crisis, we've been working on sustaining statewide standards and response times. We've also developed regulations for crisis residences, so they can be licensed, and we've modernized the path of regulations and we're introducing standards of care to help shape the practices there.

So more recently, with the increasing emphasis on equity in behavioral health, with the real attention to the role of law enforcement in behavioral health crises, and the impact of COVID on the behavioral health system and increasing need for services that we've been talking about, and really capped off with the Federal funding that Emil was talking about as well as the Federal implementation of 988.

We're really moving into a new direction with crisis services for the community, a much more intensive phase where we're developing and supporting lots of new program development., so I'm going to turn it over to Denise to tell you more about that.

>> DENISE BALZER: Great. Thank you. Next slide, Ben. Good afternoon, everybody. I'm Denise Balzer. I'm the Director of Crisis Services at OMH. So, our work is focused on development crisis response system for all New Yorkers of all ages, and the components of those, of this system include our 988 implementation activities, mobile crisis services, crisis

residences, crisis stabilization, CPEP and emergency rooms as well as linkages to community services and supports. Next slide, please.

Part of the comprehensive crisis response system overview has these essential elements. They're all multiple elements in the comprehensive system, but these three elements are critical. Someone to call, which is the development of our 9 8 8 Regional Crisis Response Hub. Someone to come, mobile crisis response teams for every county in New York State. And somewhere to go, the development of crisis residential programs and crisis stabilization centers. Next slide.

What's critical about crisis systems is the alignment of these services, the coordination, the collaboration, the communication between these services and moving individuals to services that are recommended, that are needed, that are requested by the individual who is experiencing a behavioral health crisis.

So, what we know is that if someone calls 988 or calls a crisis call line, 80% of those -- of those needs are resolved over the phone. That means no additional services are required after that time. Of those 20% that are left, 70% are the -- or the 20% that may be referred to mobile crisis teams. Then 70% of those crises are resolved through that mobile crisis intervention. If individuals go to a crisis facility such as a crisis stabilization center or a crisis residential program, 65% of those are discharged back to the community without additional crisis services needed, meaning emergency room or hospitalization.

And all of those individuals who have received those services, 85% of them remain stable in community-based care. So, if individuals are experiencing a crisis, emotional distress, substance use related crisis, their ability to be able to connect with services is critical, and the ability to build a system that talks to each other is extremely critical.

So, the elements that impact this alignment are outside of mental health services are 911, so we've been collaborating and talking with 911 call centers on how do these services connect with 911. How are services that are not police, fire, or EMS related get routed to a mental health service? Connection with law enforcement, how can law enforcement be our partner in these services? When are they necessary? When are they absolutely not necessary and mobile crisis services are sufficient? What happens when these services are used efficiently, is that there is decreased unnecessary use of emergency rooms of individuals going to jail, of individuals needing in-patient services. So, we are looking at all of these elements and working with all the players that are part

of these services in coordinating and moving the system forward. Next slide.

So, the first element, someone to call. 988, so 988 is through the National Suicide Hotline Designation Act of 2020, the National Suicide Prevention life lines were designated as 988 call enter centers and the 988 number is the number to connect to the national suicide prevention life line. So, 988 will provide suicide prevention services and also provide support for emotional distress and behavioral health crisis. They provide free and confidential emotional support 24 hours a day, 7 days a week. This 988 number will eventually replace the 10-digit national suicide prevention life line number. The reason for 988 is it's short, easy to remember, and provides immediate access to individuals needing services.

And currently OMH is leading the development of the 988 statewide implementation plan through a grant through Vibe represent Emotional Health and SAMHSA. And this is by a statewide coalition and the coalition includes state agencies, advocacy groups, 911 call centers, law enforcement, and other interested parties that requested to join the coalition. next slide.

The second element of the crisis response system is mobile crisis. So, New York State and OMH and Oasis approved mobile crisis providers to be able to be reimbursed for mobile crisis services. These providers will have an opportunity in the coming months to participate in technical assistance programs to improve their billing practices, to improve their program guidance and development, to enhance and develop mobile crisis services already in existence, and expand into counties that do not have mobile crisis.

So, funds will be available to those mobile crisis providers that are currently approved to participate in technical assistance and provide support to their programs, and they'll also be competitive funds for development and mobile crisis in those counties that are uncovered. We'll notify the community of this application process when it's complete. Next slide.

So somewhere, somewhere to go. Crisis residential programs, in 2019 the crisis residential regulations were updated and with a thought that with the HCBS short term and intensive respite programs will move into a crisis residential licensure, and that will be eventually and is currently being reimbursed under our Medicaid managed care benefit. And eventually the state plan.

So, these crisis respite programs are continuing to be transitioned into licensed crisis residential programs, so we identified individuals that received crisis capital for

development of crisis residential programs, and there will be funds available to support the startup of these programs and will be announced in 2022.

What is important about these crisis residential programs is that the updating of the crisis residential regulations were really driven by the peer model, to think about what individuals want when they are in a crisis and what would most benefit them. So, we worked closely -- we looked at the HCBS models, talked to peer respite programs to inform the development of those services. So, the residential crisis support model is most closely aligned to the peer model and short-term crisis respite. Intensive crisis residence offers both peer support services and treatment services, and children crisis residences provide treatment and support services.

Next slide, please.

And crisis stabilization centers, so last year crisis stabilization centers were included in our Article 36 legislation. OMH and Oasis are jointly creating regulations to guide the development and operation of these programs, and they're voluntary outpatient programs for individuals, regardless of age. The services are available 24/7, but individuals will stay less than 24 hours. Our intention is that these services will be connected to other services in the community very tightly, and there will be availability for individuals to move to other levels of care quickly and as needed.

The public comment period recently ended, and we're reviewing these public comments and incorporating them into the regulation as well as informing our guidance, our program guidance development. We will be notifying the community of funding opportunities for startup and initial operating funds after the regs have been published. -- finally published.

There are two types of residential or crisis stabilization centers, the supportive crisis stabilization center, that's most closely related to the living room model, and it is a peer-informed model. The idea of these stabilization centers is not to mimic or make a small emergency room. It's to create an environment that is peer led, that it provides a service to individuals that they can feel comfortable and be open and receive services when they're in crisis.

The intensive crisis stabilization center incorporates the support of crisis stabilization center philosophy with peers, but it also includes treatment services. And these services are both OMH and Oasis services and they're not just one or the other. next slide.

And CPEPs, Comprehensive psychiatric Emergency Programs, 22 CPEPs in New York State and majority are located in New York

City, but these CPEPs are connected to a hospital emergency room, they provide triage, services, evaluation, emergency observation, mobile outreach which includes mobile crisis services, and follow-up services. These are as Chris had said, we updated the 590, they're the 590 regulations in 2021, and we incorporate add triage and referral service, and it previously was called a brief evaluation, but we wanted to make sure that there was the ability for individuals to come in it if they needed like an immediate attention and triage and to get the services that they need quickly and leave.

We also expanded the mobile outreach to incorporate mobile crisis services and the ability to do follow up easily, and we also created a pathway for satellites of currently operating CPEPs. Next slide.

And the last part of this system are the community services and supports. What we know is that after an individual has been in crisis and if they need or want services for follow up after that time, that they need to be linked to services. And that doesn't mean giving a phone number and a referral. It means really helping them to make that connection and allowing the opportunity for providers to check in with individuals to be able to make sure that they've engaged in those services if that's -- if that's what they want. And if not, to help them to figure out what they do need. And if there are other services that are available for individuals, apart from treatment services. Perhaps there is someone who needs help with housing or food or substance use disorder services or medical services. All of those, the ability to be able to connect individuals to these services is critical as part of the comprehensive crisis response system.

>> BEN ROSEN: Thank you, Denise.

>> DENISE BALZER: Thank you.

>> BEN ROSEN: Back to Dr. Sullivan.

>> ANN SULLIVAN: Thanks, Ben. I know we're running a bit late so I'm going to go through this quickly but certainly look at the slides and contact any of us for any further information if it hasn't been clear. One way to think of what a public mental health system should do; is it should be prevention at every stage of possible prevention. There is three parts of prevention. One is primary, which is prevention that basically happens to prevent anyone from having a mental health problem or substance use problem. It's early, early prevention.

The second is secondary prevention, and that means the kinds of things when we screen to detect the early stages of mental health problems and prevent them from becoming long term or chronic. The third part of prevention is working with

individuals who do have a chronic illness and how do you prevent a chronic disability of that chronic illness. So, if you think about these as the way a public mental health system should look or work, if you're going to be working for the mental health of all New Yorkers, you have to have primary, secondary, and Tertiary, a way to look at what we're trying to do.

The areas we're not quite as strong quite frankly is primary care prevention and I want to look at the next slide. The biggest reason for primary prevention is the studies and I won't go into it because most of you know them. Early problem, early problems of abuse, neglect, poverty, individuals, families that are in conflict and have mental health problems, that those early experiences with kids can lead to longer-term experiences as adults with mental health and substance use problems, but bigger than that, they can lead to independent and physical health problems. And they found more cardiac disease, pulmonary disease, more of everything. Basically, preventing those early ACEs, the childhood experiences that are negative, if you can prevent those can you really influence in a big way the future health of an individual. Next slide.

That's not separate from all the environmental from you influences and I just put this up to show it's complex we still have to try to address them.

We worked on primary prevention in two key areas. The first area is in primary care. And one of the major initiatives that we've had is OMH HealthySteps and put a mental health person in a pediatrician office to work with families and youth before you see actual mental illness, but you know they're having trouble and that the family may be dealing with a lot of stress, maybe they lost a family member, maybe they had problems with being able to -- loss of jobs in families, it's a big impact. Maybe the child is having difficulties in school and how do you begin to help them. So primary care, HealthySteps does that in the pediatrician, primary prevention. Project TEACH consultation with the pediatricians with a psychiatrist, someone saying yes this is a problem, or this can be prevented, again primary prevention.

Then the collaborative care we know about depression and anxiety in primary care for adults.

Secondary is schools, and here we've done a tremendous amount of mental health education act is in my book one of the best primary preventions where you actually go in and start talking throughout the lifespan of a kid in school about mental health issues from pre-K to grammar school all the way up to high school. A Parent Corps is a pre-K program we have in a number of schools across the state where parents get

specialized training. The other thing which is more primary into secondary prevention is school-based clinics, and we did a major initiative here to increase school-based clinics which are increasingly important as kids go back to school.

Now with what we're facing in terms of kids going back into school after being out for a good period of time last year and all the problems with the pandemic, primary, this kind of primary intervention in schools is critical so we're doing a tremendous amount and I won't go into all the details, working with schools on trauma-informed care, dealing with kids coming back, parent anxieties, kid anxiety, the network being informed, all of these things doing intensively and suicide prevention in schools and helping individuals, teachers, families, parents, kids, to cope with now what's the pandemic even though some of it is still ongoing.

Next couple of slides quickly. Trauma informed network I mentioned, and you can go to the website and see all the resources that we've put up for schools and for other providers. Next slide.

Suicide prevention, again, major efforts in schools, major efforts of gatekeeper training, major efforts across the provider system. Next slide.

So, that's partner prevention and secondary prevention, but then often we get to the point where kids and adults have a tertiary help, prevention to prevent the long-term disability sequela if you're living with a mental illness and this is where building system and services comes in for adults and kids. Quickly to go through, we are aware there are things we need to do to improve both systems especially for high-needs kids. We're going to be developing systems across, we're going to be using community-based systems, new intensive systems, redesigning the residential system, and then some cross-systems work. So very briefly to go through it, next slide, systems of care, we have sent out systems of care grants across the state to begin to develop in counties that don't have systems of care on how to work together. From the very beginning we talked about coordination of care and people talking together, so it's critical that systems of care, we know it works, it gets various agencies, various groups together to work for kids and families with high needs. Next.

Community-based services, here we're working very, very diligently to increase our CFTSS services with some of the federal money that we're able to continue the rate reimbursement increase by 25%. We're working as Emil said a lot with kids and family work in terms of supporting staff, recruitment and retention, and various technological. So, expanding community-based systems for kids is a big initiative.

Next.

Youth ACT, we're greatly expanding ACT teams and expanded four more already in the city, and we'll be growing another ten across the state, statewide. This is community-based services for kids. I know that those of you who work with kids with multiple problems are aware that we've lowered, some of the residential RTF beds decreased but we're putting in place high-end community-based services and one is a big massive expansion of youth ACT across the state.

Residential programs, again, we're looking at giving it additional dollars to help our community kids residential to do really improved evidence-based practices in terms of working with kids. And we've worked and redesigned some of the residential treatment programs, residential treatment facilities that are application process, helped with vacant beds in terms of reimbursement when kids are not in those beds, and increasing ability again for evidence-based programs, and then there will be workforce dollars as well allocated to the residential treatment facilities in order to recruit and retain workforce. Next slide.

Cross systems work, we've been working very closely with OPWDD. We're well aware there are kids with high-end problems that really need a specialized assessment and then specialized residential step down and then specialized outpatient care. One thing we're very excited about is the unit we'll be opening up in collaboration with SUNY update and opening for kids with dual diagnosis developmental health and mental disabilities and residential expanding on a program which we started in the same area that we'll be expanding for youth with dual diagnosis, and in again with collaboration with us and OPWDD to work on especially some of the residential step-down services that are needed. Next slide.

I'm going to try to go through quickly. Rehabilitation services for adult, that's a whole track of things that we're doing for HCBS and CORE, the rehab model, expansion of peer services, and Emil mentioned this. Ontrack New York expansion, hopefully we'll get close to almost 85% covered New York wide for first episode psychosis, work on employment, and then diverse, re-entry, and intervention for those individuals that touch the criminal justice system.

I'm going to flip through the slides because I really want to hear from you guys, so let's go just flip quickly. Of course, we talked a lot about this. These will be easier to access, the adult HCBS and CORE services. Next slide.

These are the CORE services, you kind of all know this so go to the next slide.

Again, moving clinics to the rehab model and this will

enable increased use of peers and as well as increased use of offsite services something we wanted for many years. Next slide.

Services out of the clinic that include demonstration services out of clinic, and certified community behavioral health and first episode and peer services, a block-grant dollars to expand peer services.

Ontrack we're expanding, next slide.

Employment, we're still at about 19% employment across New York State for individuals with serious mental illness, and that's tremendously low. We have to get that better so we have a number of initiatives that hopefully will move that needle to a much higher number. Next slide.

And then lastly, just to know that we are working diligently to assist our counties and to assist our providers with individuals who managed to get into and involved with the criminal justice system to divert them from jails and get them the treatment that they need. There are dollars in the block grant which will be put forward for this, and also, we do a tremendous amount of work for individuals that unfortunately end up in the prison system that they do not return to the prison system. Those initiatives, we can go into more detail at some point if anyone would like to know, but that's another critical piece to stop that flow of individuals from the community into jails and prisons.

So, Ben, I'm going to stop there because I think we want to hear from people. So perhaps you can start with some of the discussion comments, and just what people might want to make. Handing it back to you.

>> BEN ROSEN: Ben yep. Thank you, Commissioner. As you can see on the screen, we have some instructions on how you can engage with us here. We have the hand-raise button located on the right side of your screen if you would like to speak. You can also enter comments in the chat. There are a number of comments and questions in the chat. We do ask that you direct them to All Panelists. I'll go through the people that have their hands raised now. Please be a little patient. We have almost 1,000 people on so that speaks to, I guess, how dedicated folks are.

So, first though we have Harvey Rosenthal and I'll unmute you and you have 3 minutes.

>> HARVEY ROSENTAHL: Thank you, Commissioner and all of your staff. We can't thank you enough for all of the hard work you've put in. I think some of us know more close up all the work that you put in through this incredible time and how challenging of a time. Challenging is the word for me because I got a lot to say and only about 2.5 minutes.

So, I'm going to go fast. I'm going to say what it's like and what we're concerned about. On crisis, thank you so much for the continuing of crisis services. It's very exciting. We like particularly that you have a voluntary design for the stabilization centers, and you created the option for the peer and recovery option. That's, you know, as opposed to the clinical one. But we need to have a large number of these, and we need to make sure that there is a lot of community follow up. We're going to help people in a crisis, so do we really have enough access and quick enough access to the places that people would need after one day of stabilization?

And at 988, we really look forward to the executive and legislature to reach an agreement so that those programs are funded, so 988 is actually funded. I think we're waiting for legislation there.

Criminal justice, we're really looking for your support in mental health alternatives to police. I don't know if you want to say more about it at some point. We know that, as you know, we were very much against solitary confinement and very glad the bill passed. I believe you're going to be providing alternatives to solitary treatment in the prisons, probably not enough time to hear more about it. But I'll follow up with you on a number of these, but I just want to put these out for the record.

On workforce and agencies, really appreciate the allocations. Emil and, you know, I know you're making it sustainable in some areas, but we can't get enough. We're just devastated out there. And we need its executive budget, and I'm just saying this for the record to include a cola, point for a cola and large investment, over the years we've been shorted. The need is so great.

And racial equity and justice, I think we all know there is a disproportionate representation of people of color in jails, in prisons, in hospitals, and who are getting AOT services, so we really are looking for -- I no he you're working and have an office that works on this, but cultural sensitivity and responsiveness. We must be able to get these AOT orders down and these arrests down and the fatalities down.

On the most integrated setting coordinating council, thank you so much for your leadership. You and Amanda have been terrific. The idea of committees co-led by advocates and agencies is terrific. But we're looking for the hiring of a chief disability officer, so we can carry those things forward through the executive branch and see outcomes in the remaining year. And we love a new updated homestead plan and your help with that.

Social determinants of health, so important that everybody

agree, but we don't have outcome measures established in this case by the health department. And I know that there is some agreement over there about that, but we can't work fast enough to be able to define housing, employment, and financial supports. Because if we don't, then we won't see more, particularly for the managed care side.

Finally on CORE, we're so grateful for what you've done there. It's a historic improvement. Overseeing and overcoming the problems to access. We're just hoping that there will be that access and that the people will enroll and they'll be offered some support to enroll, and that the quality of the CORE services are there at the best. I'll stop there because -- oh, peer services. I understand that you're running peer services through the clinics, and in general that you'll have it out there but very worried about fidelity of peer support and not sure clinical providers -- I am sure the clinical providers are not equipped to hire and supervise peer supporters in most instances, and we hope that you offer some training and TA or whatever else is necessary to ensure the fidelity or we'll have a lot of peers out there.

Finally, thank you for the allocation earlier today, the 4 million dollars to expand the workforce. I'm done.

>> BEN ROSEN: Thank you, Harvey. Okay. Next up we have Steve Coe. Go ahead.

>> STEVE COE: Hi. Thank you very much. That was a surprise. I just want to commend you on the work that you're doing. I will note that value-based payment was not mentioned once in almost an hour and a half shows and but was talked about social determinants of health, you didn't use that term but you used employment and housing and so forth as critical components of crisis services. If those things are going to get paid for, we need to move to a payment model that rewards doing that work. There was supposed to be a transformation in Medicaid services, and that effort was led by a hospital executive and a union executive, and I think there is an opportunity now. We have a new health Commissioner, very oriented toward social determinants of health, Dr. Basset, a wonderful OMH Commissioner, very receptive legislature, and I think that a summit of some type with the departments and the legislature and users and providers of services in a room, and not managed care companies -- they're welcome to come too, but they should not be driving the change. Figure out how to pay for this stuff using the Medicaid dollars that are still going to emergency rooms and hospitals and medication. There is billions of dollars in the system. The budget alone for OMH alone is 5 million, but we scrape by. The crisis programs I was delighted you have the license now, you have them allowable

for payment, but they're not being set up and run by providers because they're not financially viable. So, until there is a model that really rewards the development of these things, it will all be on paper.

Much like health insurance had to include mental health services now, people can't find a provider. So, unless you make adjustments to the system to actually expand the availability of these services and rethink how services get paid for, I'm afraid people are not going to be able to take advantage of the stuff you're putting in place through regulation and so forth. I'll stop there. Thank you very much.

>> BEN ROSEN: Thank you, Steve. Just a note to speak, I'll identify you but we do have some requests to have people identify themselves when they're speaking before they start speaking as well. So next I have Susie Mariott, go ahead. Okay. Give you a couple seconds. All right.

Next up I have Ashley Brody. You have 3 minutes.

>> ASHLEY BRODY: Thank you very much. Yes, can you hear me?

>> BEN ROSEN: Yes, we can.

>> ASHLEY BRODY: Great. Thank you very much. Yes, I am Ashley Brody Chief Executive Officer of search for change, a nonprofit organization that provides OMH licensed and funded supported housing vocational rehab and other community-based services for our shared population. I would like to echo some of the sentiments made previously, thanking Commissioner Sullivan and all of our colleagues at DOMH for hosting this town hall, the opportunity to submit this testimony, and exceptional leadership and support you provided during the COVID pandemic. This is unprecedented to say the least, and none of us anticipated living through this, and I must say that despite all of the challenges and constraints, you provide an extraordinary degree of technical support and guidance during the process and we do appreciate that.

For the purpose of my brief testimony, I simply want to elaborate on a particular interest of concern for me and many of my colleagues at housing providers, and that is the current and future state of affordable and supportive housing. I think the value of housing to all individuals, most notably those with special needs is both self-evident and affirmed by multiple authorities. And in short, we have a safe and secure place to rest one's head, health and recovery are exceedingly difficult or if possible. The plans regularly support housing as commodity as paramount importance of additional resources must be committed. Similarly, as was discussed today, an emerging body of evidence concerning social determinants of

health and privacy and recovery process, recognizes safe and supported housing are integral to health and stability. To this end, I must thank and acknowledge OMH for advocacy and securing much needed rate adjustments. I was pleased to hear Emil indicate earlier today that we will be receiving these adjustments, the parameter, and extent to which they will help us make up for some of the ground that we've lost in recent years to inflation and ever-increasing cost of serving the high and vulnerable population. As Harvey said, it's never enough and the demand always outpaces the supply and we do appreciate your support and are eager to see how this materializes.

I will add however the funding welcome and appreciated as it is, it truly is, is and in itself insufficient to address essential challenges supported housing providers face in achieving objectives. As we continue the study implementation plan and promote community-based alternatives to institutional care and a noble care that was unanimous support of the recovery community, the continuous and rapid development of appropriate housing is absolutely essential. All too often, however, housing providers seemingly unsurmountable obstacles to new development when the missions -- when multiple municipal planning and zoning boards in the communities they represent. Despite collective efforts to educate the public and combat stigma against individuals with behavioral health conditions, used prominently in the landscape. I recognize OMH doesn't have the power or authority to influence the practices of planning authorities or the sense of the general public and move this requires coordinated approaches among broad coalitions of stakeholders and nevertheless I urge OMH to entertain a more expansive role in planning and activities as this is the housing unit in need. I thank you for your support and appreciate the opportunity to speak to you today.

>> BEN ROSEN: Thank you, Ashley. Okay. Next up we have Emrita Ramirez. 3 minutes, go ahead.

>> EMRITA RAMIREZ: Good afternoon, everyone. My name is Emrita Ramirez and thank you so much for having me here on -- this is actually my first time joining in, and thank you so much.

I am a person of inquiry of 28 years and transitioned out of clinical and merging into the peer integration after about 19 years, and I would like to just address a major concern for the peer initiative where I've seen the work as of 7 years ago, we've come such a long way. However, the struggle is where the clinical staff are still struggling with providing appropriate peer supervision for the peers. And I've seen where it's successful approach and the failing approach. I know that COVID hit, and I know that we have taken a few steps back;

however, moving forward, we really do need training for the clinical staff and leadership management, and more structure for the peer-driven. We're getting lost out there. A lot of the peers are doing trainings, coming aboard in the workforce and then there is just -- they're kind of left behind. There is still a little bit of stigma still on the peer services, the roles, and I am so happy to hear that there are going to be some changes implemented with the peer integration.

And as I mentioned as a person of recovery, it's not a one-size-fits-all, and it's not a one-sided position. This is about a profession, and we can grow. We just need an appropriate guidance and more of a, like a step-up type -- maybe you know, making someone a peer supervisor within the modality so someone that truly understands the peer model. I thank you so much for inviting me on here and I appreciate this time.

>> BEN ROSEN: Thank you. Next up Andrea Smith, you have 3 minutes, go ahead.

>> ANDREA SMITH: Thanks. I'm Andrea Smith executive director and President and CEO of the New York State Coalition for children's Behavioral Health. We consider ourselves the leading voice for access to children's behavioral health services for children and their families in New York, so I will commence with thanking you, but you know we have appreciation for the expansion and the fact that OMH has acknowledged the request to set aside 25% of new federal funding for children and family services.

We are advocating that that precedent be taken up by Oasis and other state agencies serving children and families when any new state, federal, or settlement funds come in to the system that they be allocated for children's prevention treatment and support services.

We do have points of reform which we've been communicating regularly. I'm sure you're getting tired of my letters in your inbox, but we are concerned about the failing effort to consolidate program oversight within the department of health as opposed to the Office of Mental Health for children's services. We're also concerned that the promise of managed care has not benefited children and services, and we have outlined those concerns to you.

A recent independent learning collaborative on the CFTSS rates have found the rates to be 50% insufficient to meet the regulatory requirements, so the 25% rate increase, that's coming through the enhanced FMAP, while it's encouraging, it is not sufficient.

And, you know, we need to stop the alarming drop in children's RTF beds which have shrunk from 533 beds in 2013 to

184 beds today and news of additional providers dropping out of the service and leaving kids stranded. It's happening every day. So, our recommendations, which have been outlined in our communication, include addressing the surge in operating costs related to inflation with a 5.4 consumer price index inflation rate trend. A specific 100-million-dollar children's mental health workforce, and careful attention to the 115 waiver and surprised no mention of value-based payments, but you know 17 billion is what DOH would like to get from the Federal government as a surge in Medicaid. We can't turn our eyes away from that money. The proposal includes a billion for workforce, but really only to prepare the workforce for the next pandemic. Violence in schools is encouraging districts to put police back in schools. I mean the impact of this pandemic and the need for workforce is right in front of us, and the focus on VBP and an initiative for complex care cross systems high-needs kids is definitely a priority for us. Thank you.

A.

>> BEN ROSEN: Thank you. Next is Susie Mariott. 3 minutes. Go ahead.

>> SUSIE MARIOTT: Oh, my name is Susie Mariott. Positive changes sometimes throw weaknesses in the system of care which has a negative downstream effect and sometimes it takes time for these issues to surface. So, examples of this include available psychiatric, state psychiatric beds, so downsizing the state system, the OPWDD residential option changes, but I'm glad to see that you're addressing that concern. Bundled services for children, and care management restructuring and more recently we're seeing issues with the new bail reform, we're starting to see issues with that as well.

So, these policy changes are extremely positive in many respects, but can also have negative impact on providers, patients and families, so we need New York State to be open to looking at these issues, so looking at those outcomes in the future when policy changes are introduced. So, we urge OMH to request the governor's office to gather a group of stakeholders across all agencies and budget silos, and that's important too, to analyze the impact of these policy changes on a longer-term basis on the OMH system of care and the patients that we serve. So, and then if we identify patents, what appropriate measures and policies can be proposed in the future?

So, health reform in New York State continues to work towards reducing in-patient bed utilization which is really, really important. However, there are a small cohort of people that do need a longer-term care, and they often get bounced around from community to hospital to hospital, and that isn't

good for them. So, orders of transfer should be at zero before any more state beds are closed and there needs to be more flexibility to take more patients in the state system and have a surge plan at times of imperative need so that the community system can continue to function, and that's really been tested over the last 19 months for us.

Patients who are associated with the OPWDD system of care are often brought into hospital emergency rooms when the patient's behavior is unmanageable and providers need OMH's strong advocacy to support OPWDD in establishing an emergency response in these situations because patients often stay in medical beds or emergency rooms waiting for services because we're not quick enough at responding, and those environments are very high-stimulation environments, and it can be negative on the individual patient concern, but also families, other patients, and staff trying to provide care for them. Situations can become quite dangerous at times.

We think care and case management is the key to reducing hospitalizations and ensuring the recovery model, so we're glad to see there is more advancement and focus on that and crisis intervention as well.

>> BEN ROSEN: Time.

>> SUSIE MARIOTT: The only final thing that I want to say is that we would like to see more research grants or funding for integrated services, so budget silos, so maybe police and health working together, so funding coming from both streams and not just OMH and at that might be quite interesting to set up joint funding and service provision solutions. Thank you very much. We will submit the rest of our comments in writing.

>> BEN ROSEN: Thank you. Okay. I'm sorry. Just trying to -- I'm having a bit of a technical glitch but we'll go to -- I do see some people who would like to speak and I'm trying to find them on the list. Okay. Hold on one second. Dr. April Akock, you have 3 minutes go ahead.

>> APRIL AKOCK: Can you hear me? Perfect. I actually put my comment in the chat but I'll go ahead and just read it. So, I just want to say thank you for today. This is just very invaluable information. I really appreciate that and what the State is doing. My question is regarding the health care disparities, especially in the Black and Hispanic population. I wonder how will the state require services to be in the community where the minority population is located to help increase access as well as decrease health care disparities? Also, I'm wondering how will increasing diversity be required in OMH regulations and what will be the consequences if services don't increase diversity in staffing and their clients

especially with all of these dollars going into organizations. Also, I'm wondering how is racial trauma being incorporated in state OMH systems and prevention plan, crisis stabilization, et cetera. Thank you so much for your time and thank you for hearing my question. Questions, I should say, (Laughing).

>> BEN ROSEN: Okay. So, we have some questions in the chat that I think we should get to. And, yes, the slides will be available as well as the recording we'll post it on the OMH website and make sure everyone who attended this meeting or registered for this meeting gets it.

So, we have a question about the community mental health worker title, will that be a separate work code profession by the Department of Labor and funded with livable wages, or will it be similar to the DSP title that is really underpaid.

>> ANN SULLIVAN: Let me just answer both the prior, which I took a few notes on, and this question and very quickly because I know we don't have a lot of time. But on the disparities, I think that we are requiring for any of the RFPs that we're sending out, which is the Request for Proposals for the funding that we're distributing, that the individuals who are applying clearly address the issues of racial and ethnic equity in what they're putting forward and how they're going to do that, and what populations they're going to serve with commitments for dollars as to what that they do serve those and that we'll monitor it. We have not been that specific often in the past when we sent out our RFPs, but now we will be. That will not just be for the new money but for anything in the future. That's one way in to make sure that any of the new dollars, the new programs getting set up, that we need to hear from the people who are designing them and that will affect whether or not they get the money. If they don't get the money to do it, they don't come up with a robust plan to serve the communes and serve the communities in the most in need. The consequences of that are the way we do things and the way that we continue with the money, but we will be monitoring and reading the data and looking, as I said earlier, at the data systems to make that happen. So, yes, we are targeting to make sure. We are also doing a lot of training on trauma and racial trauma throughout our system. We're looking at doing seminars on that for the wider system. We have done a little bit, but we're doing more. So, but we can go into more detail.

The second was on the community health workers and we're still talking about what that might be. And you're right, it's not going to be helpful if it's not adequately paid for or people are not adequately trained, so we need input from the community as to what that might look like and we certainly have not designed it yet to any level of specificity where we're

sure exactly what it's going to look like, but it's a concept that we're throwing out there, we're going to be working on it, and getting feedback back and forth from the communities of what those lines may look like going into the future. Thanks.

>> BEN ROSEN: Thank you. I have someone with a hand raised Jennifer Trenkel, hopefully I pronounced that last name right. 3 minutes, go ahead.

>> JENNIFER TRENKEL: Hello. Can you hear me?

>> BEN ROSEN: Yes, we can.

>> JENNIFER TRENKEL: Great. Good afternoon. I think someone said it before. This is my first time attending, so this was great. I did learn a lot. I like the 988 plan. It's catchy and memorable so that's great. And thank you for all the information that you shared. I just had a question that I saw in the beginning that there is a theme of research-informed practice and you started with the numbers and the research that's guiding all the work that is being done right now. My role is that I'm a program pacer of one of the programs and what I'm finding is there is a great need as you mentioned for community-based mental health services. However, the magnitude of the mental health need, of course, requires experienced mental health professionals and the experienced mental health professionals do not want to go on to the phones. And with the growing -- with the growing teletherapy options, job options, and the new positions in schools now, it seems like the community-based services recruitment for that is even more difficult because all of the licensed professionals are opting for home -- whatever service provision that doesn't require them to go into homes.

So that being said, I wanted to know is there any research being done on from I guess polling mental health professionals, maybe in New York State, of in regards to job employment and what they look for, what brings them fulfillment, just so it can help us when we recruit because it's really difficult because once people hear that they have to go into homes, they say nope they don't want to do that, and they have an abundance of other options now so they don't have to do it. So, I wanted to know that and was this any resources or funding being put into maybe transportation? I know that's one of the concerns, probably not all of it, but just something to help with recruitment if we can say that we offer car service or we paired with a car service or work with Uber and Uber donates some of it, so like do we work with any of these existing places out there who are contributing to whatever our mission is? So that's pretty much my question. I hope it makes sense. It was kind of all over the place. But thank you nonetheless.

>> ANN SULLIVAN: Yeah. Thank you very much. I think

you have a very good suggestion here to ask the workforce and maybe we could do a quick survey of some people that might be interested. What would make it more attractive for them to go into and work with people in their home. It's not always just dollars. It's often what you say, it's a transportation, is it something else, is it that they don't have the experience of going in and would I want to get some more training or someone with me the first time, or whatever.

So, I think it's a good suggestion and I think we'll look into that and figure out a cohort of individuals that maybe we can say what would make it more attractive for you to think about doing actual work in the home, because I just know that I used to do this when I first started working and I loved doing it, but I know a lot of people, I had to convince to go along with me and they go oh, I don't want to do it. So, I think we need to understand what it is that keeps people quite so reluctant to do some of this in-home work and I think that was a very good suggestion to kind of ask the workforce what might help make it better. We'll take you up on that suggestion. Thanks.

>> BEN ROSEN: Okay. So next we have Jim Mutton, you have 3 minutes, go ahead.

>> JIM MUTTON: Thanks so much, Commissioner. I appreciate all of the wonderful things happening on this state level. I wanted to talk briefly about crisis intervention. I know there is some efforts being made to really focus on how to handle people with mental health crises, and I heard recently about some funds being devoted to the Center for Practice Innovations to do some additional CIT training with the police.

My only comment to that is to still think about folks with lived experience and bringing them to the forefront of engaging people in crises. You know, sadly, since we started CIT training in the city, we've seen 18 people with mental health issues be killed by the police in those types of encounters, and we're doing a lot of work right now to get a pilot launched which would really use people with lived experience, trained peers, and EMTs to respond to nonviolent crises as alternative to the police. So, as we think about training and working with the PD and other law enforcement officials, I think it's key to also keep in mind the role of people with lived experience and being suitable first responders to those encounters. Thank you so much for your time.

>> BEN ROSEN: Thank you. So next up we have Shana, hopefully I pronounced your name right. Go ahead, 3 minutes. Hi. I do appreciate being invited to join. I do want to just kind of throw out there that I know that there was already somebody who commented, but I do feel that I am a parent and I

am in Schenec County and I noticed that little Schenec County does not have or was not mentioned in the slides as I could see because I was a little delayed because I am at work at this time. A few questions that I have is I do feel Medicaid itself needs some extra funding in order to be able to staff homes and -- just to staff people in general. Because a lot of agencies, a lot of local agencies, at least around here and I can't speak for other areas, but a lot of local areas do rely heavily on Medicaid to pay for their staff in order to do the jobs that need to be done, and they can't necessarily do that when Medicaid is not able to fund appropriately, and people don't want to, unfortunately, people don't want to work difficult jobs when you go to McDonalds and work for higher.

So more on personal as a parent, I do think because I did work as well, I worked in Pennsylvania, so I saw differences in Pennsylvania compared to being in New York State. I find it extremely frustrating because I typically work like a 9:00 to 5:00-type job and most agencies that I work with, sometimes they're willing to be flexible, but other times they're not willing to be flexible and their times are cut off at 5:00. So, trying to get some assistance for my child who struggles, to get assistance for him after I get out of work is extremely difficult. It's not really built for those who are -- you know, their children are in school and their parents are actually at work. So, it's a little frustrating in that aspect because, you know, like I can't -- I can't do two things at once. I can only -- I have to keep a roof over my head or over our head and make sure that we have food in our mouths.

And then lastly, one of the things that I had had seen in Pennsylvania compared to New York State is that in Pennsylvania, they do have mental health clinicians and those that come into the home, including ABSS that come into the home and behavior techs and that that come into the home and help the children. We don't have that available. That is extremely important where you can have somebody who comes in and helps the children, comes up with behavior plans, and like actually views things of what's going on to help the families in order to come up with something in order to assist the families.

So, I think that those are -- especially that is something that would be very beneficial.

>> BEN ROSEN: Thank you. Back to the chat. Okay.

>> ANN SULLIVAN: I would just like to say to you as an individual, that if you wanted to call our field office in that area, we will send it to you, Ben, the information to call because believe me, I know that we're still very short at getting some of these in-home services but that's something that we want to grow, and I have to say that I'm not sure about

what's going on in every county across the state, but we would like to talk with you about what you think, you know, might be needed and what might be available but not obviously available, or maybe not yet available in your area. But that's something that we are growing, so we will get in contact with you about that. Okay. Thanks.

>> BEN ROSEN: Thank you. Is it safe to assume that we're looking at improving social work salaries as part of our recruitment and retention efforts? I don't know if that is something that Emil can respond to?

>> EMIL SLANE: I'm sorry, Ben, what was that question again?

>> BEN ROSEN: It was, is it safe to assume we're looking to improve social work salaries as part of the recruitment and retention efforts?

>> EMIL SLANE: Yes, the funds will be flexible, and provider agencies can use it for a wide range of titles based on the areas that they're experiencing the most challenges, so it could definitely include clinical titles like social worker titles.

>> BEN ROSEN: Thank you. We have a question from the chat. Any plans for reoccurring children's HCVS or CFS rate increases or just the temporary rate adjustments?

>> EMIL SLANE: The current FMAP proposals include the temporary rate adjustments, and I think that we'll continue to look at growth in the program and access to the services throughout the state, you know, as we evaluate the temporary rate increases as well as the cost of running the services.

>> BEN ROSEN: Thank you. Here is a question I think I can answer. Is 988 available now? No, not yet. It will be available next summer in July 2022.

I have a question in the chat. Will mobile crisis technical assistance be provided to help providers work with people with IDD, it's so needed.

>> ANN SULLIVAN: Chris or Denise, do you want to answer that?

>> DENISE BALZER: You know, Chris, you go ahead and I'll chime in.

>> CHRISTOPHER SMITH: Go ahead. You started.

>> DENISE BALZER: You know, that is a big question. That's something that we've talked with OPWDD about too is collaborating on training for mobile crisis providers for intervention with folks with IDD or dual diagnosis. So, you know, we're looking at that., it isn't under development, it isn't available now, but it is something that we want to pursue.

>> BEN ROSEN: Thank you. Here is another question.

>> ANN SULLIVAN: Just to echo that that we'll be looking at that very, very closely to see what's possible. I think there is an increased interest in both agencies, just as I said before, about the in-patient really working together on these issues and we're trying to design what might work best for mobile crisis in that area. So, thanks.

>> BEN ROSEN: Okay. So as can you tell I'm getting to the questions that came in during the crisis section, so to apply for funding for crisis services, does an agency need to be licensed by both OMH and Oasis?

>> CHRISTOPHER SMITH: They don't have to be licensed by both. This is addressed in the regulations which are currently -- well actually the review period is over. But providers have to be licensed or funded by either OMH or Oasis, but it's a comprehensive program that includes both mental health crisis services and substance use crisis services. So, in order to be successful in implementing the program, you'd have to have experience and knowledge about provides that whole range of mental health and substance use crisis-related services.

>> BEN ROSEN: Thank you. And who or what system will pay for the stabilization center services and space? Will insurance be part of the payment? And what languages might be offered there? If someone doesn't speak English well and calls 911, how will they understand what to do? There are a couple of questions in there.

>> CHRISTOPHER SMITH: Yep, so on the funding side, as part of the legislation that enabled us to start the crisis stabilization centers, it was included that commercial plans also have to cover the cost of crisis stabilization services. So, that's a real win and expansion for us because many of our crisis services are really only funded through Medicaid.

Additionally though, these services, we're working on a state plan amendment for all of the crisis services that we discussed today to expand the Medicaid funding both for managed care and as well as fee for service Medicaid, and we're simultaneously working with our colleagues at the state Department of Financial Services who oversee the commercial plan to ensure that all of the commercial plans cover the whole array of the behavioral health crisis services that we're working on.

>> BEN ROSEN: Thank you. Will there be opportunities to development partial hospital stabilization programs for adolescents?

>> ANN SULLIVAN: I mean, yes. At this point in time, we have -- I think there is still one or two in the state that serve kids or adolescents and I think partial hospital programs

can be very helpful for them. So, yes, if someone is interested, it's kind of a thing that it is billable to Medicaid and commercial payers, and can be self-sustaining. And we can look into it if someone is particularly interested in perhaps how to develop maybe a little bit out of some of these dollars with the startup funding to get it going. Partial programs are something that, yes, especially for kids, we should be looking at it and we'd like to grow a bit across the state. If someone is interested, talk to us and let us know what you're thinking.

>> MEREDITH RAY-LaBATT: Thank you, Commissioner. This is Meredith from the children's division and absolutely, we actually currently have an incentive grant available through our mental health block grants to really expand partial hospitalization along with intensive outpatient programs. So, if there are providers certainly that are interested in providing those services, they should absolutely speak to their field offices for more information. That information is also available on our website under our mental health block grant opportunities, and that option is available up until November 30th, so providers should get applications in by that time if they're interested in exploring that and getting some additional funding to support their efforts.

>> ANN SULLIVAN: Thanks, Meredith. Thanks.

>> BEN ROSEN: Thank you. I think we're coming to the end of our time period today, so we'll end at the beginning with a question on prevention. What outcome measures will be used for the prevention initiatives? Do we have any examples of data that demonstrate the impact of OMH?

>> ANN SULLIVAN: I think the outcome measures are going to have to be tailored to the, you know, to the particular interventions. So, some of them are longer term, and so sometimes it involves, for example, you do real good primary prevention, like what I talked about with the steps and schools, I mean that's the kind of work you really have to work on over time and that's kind of expensive to look at but we'll be looking into ways to do that.

Other kinds of prevention like the outcomes of kids who use school-based services are things we can clearly look at, whether they've done better in school, whether things are moving along better, that kind of thing. We'll be looking at some in-patient and client satisfaction about what they think or whether or not some of these interventions that we've made have made a difference.

We talk about the longer-term prevention. We will be looking at things like employment outcomes and et cetera for things like first episode psychosis. And so for each of the

interventions that we're putting in place, we will be looking at outcomes, and I think it will be kind of tailored to the specific intervention.

>> BEN ROSEN: Thank you. So, we are at 4:01. I just want to remind folks who sent in comments and didn't have a chance to have them read, we will be reviewing all of them. If there are questions in the chat we have not responded to, we'll do our best to respond in writing. We have our information via your registration. The slides and transcript and other meeting materials will be posted to the OMH Planning Website as soon as we are able to pull the transcripts and other things together. And we'll notify everyone who registered of that.

So, I would like to thank everyone for joining us today.

>> ANN SULLIVAN: Thank you so much for joining us, and thank you for your invaluable comments and questions. And we will get back to you on the other questions in the chat so that we can email you back or get in touch with you about those responses. But thank you so much for joining us and thank you for some truly excellent comments and ideas about directions we should be using going forward. Thank you so much.

>> BEN ROSEN: Have a great day.

(session completed at 3:00 p.m. CST)

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