

## Appendix: Detailed Notes on Four Provider Sessions

**6/20/19 Provider Listening Session One at Anchor Mental Health** (1001 Lawrence Street NE, Washington, DC 20017)

**Attendees: 21 Total: 10 Providers from 6 Organizations; 2 BHPC Members; and 9 DBH Staff**

- Michelle May, Executive Director, Deaf Reach
- Sandra Maciuba, Quality Assurance, Anchor Mental Health
- Judith Rose-Wilson, Clinical Director, Anchor Mental Health
- Judy Ashburn, Director of Treatment, Samaritan Inns
- Jennifer Runlile, Quality Assurance, Anchor Mental Health
- Christy Respress, CEO, Pathways to Housing DC
- Lovannia Dofat - Avent, Senior Director Children Services, Catholic Charities
- Nodia Marshall, Clinical Director, Spring Leaf Solutions
- Larry Huff, CEO Samaritan Inns
- Karen Ostlie, Senior Director, CSA, Anchor Mental Health
- Dr. Senora Simpson, President, BHPC
- Charles Gervin, Certified Peer Specialist/BHPC
- Dr. Marc Dalton, Chief Clinical Officer, DBH
- Kevin Martin, Network Development Specialist, DBH
- Venida Hamilton, Director, Network Development, DBH
- Jennifer Cannistra, Director, Systems Transformation, DBH
- Jackie Richardson, Director, Change Management, DBH
- Raessa Singh, Policy and Programs Coordinator, DBH
- Susan Koehne, DBH
- Philippa Stuart, DBH
- Patricia Thompson, Ombudsman, DBH

### **6/20/19 Overview Summary**

- **Question 1: Greatest Strengths of Current System of Care**
  - Our committed provider community
  - DBH's willingness to improve communication and get provider input
  - Growth of the peer specialist program
  - Growth of the school based mental health program
  - Increased, improved relationships with wraparound services
- **Question 2: How Can DBH Can Improve Access, Quality, and Effectiveness of Care**
  - Peer specialist utilization: Ensuring that peer specialists genuinely involved in the treatment process

- Communication: Information about services is available, accessible and understandable.
- Quality assurance and data reporting: Ensuring that priority and meaningful data points are communicated in a clear and concise way
- Person-centered systems: Services should be informed by the needs of the individual and not hindered by the system's current structure
- Integrating health and housing: Ensuring DC's policies and practices are integrated and collaborative
- Better integration of MH/SUD/physical health: Having one model, data system, and approach to treating the whole person.
  
- **Question 3: What Are Your Ideas to Better Integrate Care—Models, Processes, etc.**
  - Acknowledge that co-occurring is a third entity, with its own definition and challenges
  - We need a preventative behavioral health plan, not one built only for crisis (which fee-for service is)
  - What have other states done?
  - We need to know why people aren't coming in and when they do, we need to know what services are actually available for them.
  
- **Question 4: How Can We Improve Service for Young People**
  - Strengthen the relationship between DBH and OSSE since OSSE has early childhood programs
  - Integration should be family-focused
  - Connect with residential (charter) schools
  - Ensure that school security guards and police officers know how to recognize and appropriately address behavioral health needs
  
- **Question 5: What Are Gems and Jewels In Our System**
  - No Responses
  
- **Question 6: Anything else?**
  - There is not a provider directory on the DBH website for SUD
  - DBH should allow LPCs to provide the same services as Social Workers in order to utilize all available professionals.
  - E-invoicing has been great, but there has been an issue in the past involving POs that span a fiscal year. The process should be faster.
  - What is the status of the revisions to Chapters 34 and 63? It has been so long since this process started.

**6/20/19 Detailed Notes<sup>1</sup>**

**Q1: What are the greatest strengths of the current system of care?**

- Commitment to evidence based practices (Michelle May, Deaf Reach)

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<sup>1</sup> Note: If we were unable to identify who made a comment, we do not include any name after the comment.

- Dr. Bazron follow up: Do we have them? Are they being used?
  - They exist but she is not using any now. (Michelle May, Deaf Reach)
- Committed group of providers that represent community in many ways. (Judy Ashburn, Samaritans Inns)
- Willingness to improve communication and get provider input. (Nodia Marshall, Spring Leaf Solutions)
  - While there are struggles, there is a willingness to improve communication and to go back and forth.
  - Dr. Bazron follow up: What do we need to do to have more than a just a willingness?
    - Consistent system, i.e. a portal or avenue for getting updates, seeing changes or developments. (Judith Rose-Wilson, Anchor Mental Health)
- Growth of peer specialist program– peer specialist movement might be one of the best in the country. (Dr. Senora Simpson, BHPC)
- School based mental health program– starting younger to catch mental health, one of the best systems (Nodia Marshall, Spring Leaf Solutions)
  - Senora – schools are asking for support and welcoming staff
- Increased, improved relationship with wrap around services. (Judy Ashburn, Samaritans Inn)
  - We were able to utilize telemedicine to increase access quickly

**Q2: What significant improvements should we make to enhance and address areas, looking specifically at access, quality, effectiveness of care, and access?**

- Growth of the peer specialist movement (Charles Gervin, BHPC)
  - People think only in terms of access but other factors are important too: the experience of being a consumer, and that people's conditions change over time but the treatment and approaches don't reflect that experience. People on medication or in programs that don't need that same level of care can't always leave/change (no step down).
  - We tune out peers in conversations. Peer movement is a way to set up a different conversation about wellness, medication administration and type of services.
  - We aren't nimble enough and we don't listen enough to be able to adjust medication as needed.
  - *Dr. Bazron follow up:* Peers can offer input on how services should be offered, and the person in care should be giving necessary input to their treatment.
- Communication is not clear and not common (Dr. Senora Simpson, BHPC)
  - Most people in the community have no idea services are available. This is in part because the language is not inviting, and outreach is not responsive to the needs of the community. For example we don't use technology to reach all groups or approach older adults the same way they approach young people.
  - We are doing the same thing (same treatments), calling it something different and billing for it. We know how to say stuff but when it comes to doing it we are functioning the same as before.
  - Peer Specialist – we say we use them but they are not listened to in practice.
  - *Dr. Bazron follow up:* We have a lot of services but we use the wrong language; we have to use common language to demystify.
- Quality Assurance (Sandra Maciuba, AMH)

- She participated in the helpful ACT RBA sessions and is now wondering if there is a way to have some aggregate data to show what's going on in DC in order to lead to interventions (that are data informed). Data could inform interventions at CSA level.
  - What is Aggregate Data? Some examples could be: Are we seeing an uptick in deaths related to opioids? Are we seeing suicides? Why is that, that can we do with this data?
  - *Dr. Bazron follow up:* Aggregate data is data across the system.
  - Dr. Dalton follow up: Point of clarification, are you thinking of an epidemiological view?
    - Yes, but also looking at incidences to see where we can go with that.
- *Dr. Bazron follow up:* What are five data points that would mean the most?
  - Availability of skilled workers: We don't know who is being trained; there is a waiting list of consumers. We don't have the work force. We can count the number of people who need treatment. We screen and find that there is a need but we can't do anything with that. How do we get people to go and stay in the field? People are getting about 4 hours of training, that isn't enough. (Dr. Senora Simpson, BHPC)
  - Dashboard points (capture people's wants): Peoples' needs change, and there is no flow for housing or services. We don't collect data on housing needs, and there is no flow for people to live their most independent live. How are we taking the data to meet desires? How do we capture people's wants and then influence the system based on that? We spend a lot of time just getting people in wherever but we haven't done the next step of developing a flow for what's next. We have the technology but our housing resources and our mental health resources don't match to one another (Christy Respress, Pathways).
  - Are children getting better? (Lovannia Dofat, Catholic Charities)
    - There are so many agencies and services but are they getting better?
    - How can we pay for "early engagement" (readiness) services?
    - *Dr. Bazron follow up:* Does CAFAS tell us that?
      - Not for every single child. They'd have to get services in order for their data to be captured. They aren't reporting it out yet.
- Relationship between housing and SD/MHRS services (Larry Huff, Samaritan Inn)
  - The housing world and the health world (DBH is a subset of health world) operate in different "jet streams." In the housing world, the housing continuum is dominant; there are systems and infrastructure in place to support people, and it's working. Health is not in that "jet stream." People are in the housing continuum, and DBH is separate. Since housing is so available, individuals get focused on just housing and neglect SUD treatment – we need to be integrated at all levels.
    - For example, Samaritans Inn has a program for level 3 treatment for women and children (residential substance use disorder services, high intensity, 24/7 for 6 months). They are having difficulty getting people into the program because they have an opportunity to get housing in lieu of services. The opportunity to have only housing, without services, means they don't stick with treatment.

- Example of woman from Georgetown: A homeless woman with mental health issues received housing. After 28 days, because she isn't homeless anymore, the provider couldn't get her into the treatment center. She was having problems and didn't like being in her apartment along though. How do we integrate health and housing?
- Virginia Williams is the central clearing house for women and children. Providers can't break into that system. We need the health community to engage and address the issue.
- *Dr. Bazron follow up comment:* Health is not integrated into housing.
- No one is connecting someone to follow through, so services are following a continuum. Money and services are structured, and when going from one place to the next, there is an abrupt stop. People are following the needs of the system. People often say that we need better service integration and that services are not wrapped around the person. The existing system structurally does not support this. (Charles Gervin, BHPC)
- The housing community doesn't have the same priorities as treatment services. (Larry Huff, Samaritan Inns)
  - Point of disagreement: This might be true when there is no oversight or expectations, but if there is no Housing First there isn't housing on the other end of treatment. When Housing First is done well, it works. Our system doesn't pay for harm reduction or services before they get to the door. It can go both ways; we need treatment and treatment providers. (Christy Respress, Pathways)
- *Dr. Bazron follow up:* Service integration is important. We need process mapping and to put policies in place to connect the dots, we need to put services in place around the person rather than other way around. We aren't paying for services that are prerequisites--how do we pay for early engagement and harm reduction services?
  - As the population ages, we need to find housing for them. Finding housing for someone with a wheelchair is impossible. We have elder people who need CRFs, but they are on the second floor. (Jennifer Runlile, AMH)
  - We need to look back at how we set up our rules, re: LOS in needed services. We aren't very honest about how we apply the rules, and we can use the rules to our advantage. (Dr. Senora Simpson, BHPC)
- *Dr. Bazron follow up:* How does medical necessity influence this?
  - We have rules and policies and procedures that can just ignore the medical necessity. The politics also plays into it. One doctor can override the other.

**Q3: What Are Your Ideas to Better Integrate Care—Models, Processes, etc.**

- We need one data system for MH and SUD; providers do not want to have to worry about putting someone in a bucket instead of spending time with them. We want a streamlined payment system. (Michelle May, Deaf Reach)
- *Dr. Bazron follow up:* Other places in the country have codes for co-occurring substances but providers also have to be able to deliver those co-occurring services. Are people willing to move in that direction?

- We want to be able to meet needs of clients. We know there is a need to its ensuring the integration of the system, training, TA. Maybe we can't provide the whole range of services but at least some (Karen Ostlie, Catholic Charities)
- *Dr. Bazron follow up:* What would it take to change the whole system, what model do we use. What's the process needed to craft that model?
  - Acknowledge that there is a third entity, co-occurring – We should establish a common language that identifies what's similar and what's different. There are some stark differences between SUD and mental health. We need to be able to articulate what's the same and what's different. (Larry Huff, Samaritan Inns)
    - *Dr. Bazron follow up:* How will that be used?
      - This drives everything else – certification, starting from the beginning. From a professional practice vantage point, what is it, what's different. Practice 101.
  - A Preventative behavioral health plan. Our approach is a catastrophic model. A plan that stops people from reaching catastrophe and then if people become well, there is no money to sustain them. The preventive BH plan could address maladaptive behaviors like prevention. Can you identify people going down the (wrong) road before they have problem? (Charles Gervin, BHPC)
    - *Dr. Bazron Notes:* IMR, illness management recovery
    - To Charles's point about prevention, we are concerned about who is not coming and why. What is that package of stuff that people need? What needs to be available when they walk in the door? (Michele May, Deaf Reach)
  - In fee-for-service model you reward volume, it's a crisis model. Speaking with street outreach workers can give you info like which providers show up—not all providers do the work they should be doing. There isn't oversight at DBH saying “have you seen all your consumers on your roster? What did you do as a provider to be creative to find your consumers?” But DBH will need to pay for changes to happen. And the discharge policy is not helpful. (Christy Respress, Pathways)
  - We need to go to the Federal level, where in the US has merged the two? Department should be run by the system not by the person; we need to develop a system that is truly integrated and built on a system, not on who is leading it at the time. (Dr. Senora Simpson, BHPC)
    - *Dr. Bazron follow up:* What are models that have worked well? Everyone is struggling around the country, but we can focus on the system development, and form follows function.
    - What is available for people who come into the system? If you don't fit in a bucket, what is available? If you've improved what is available? (Judith Rose-Wilson, AMH)
  - *Dr. Bazron follow up:* We forget that we are one leg of a 3 or 4 legged stool, and we haven't really linked with those entities. And if it's not in our box we assume it isn't there. There are a few models that have been able to link systems, such as Colorado.

**Q4: How do we do a better job at expanding and improving our services for young people?**

- There is no coordination there, we still have kids who just hover and really need care. There are frequent users of systems, who go to the hospital but don't make it to the threshold of

needing to be admitted so they go home. They need services but they aren't severe enough to get services. Even with Homebuilders, they didn't meet criteria because they weren't ready to give up on their kids. (Lovannia Dofat, Catholic Charities)

- *Dr. Bazron follow up:* Can you tell us more about that model?
  - Homebuilders: This is the step right before they need to enter foster care; parents are told if you don't do this, we will take your kids away. It's a moving target. The model is something to look at, especially given school-based mental health program.
- What DBH's relationship with OSEE? They have an early childhood program so DBH should keep building on that. Interventions should be family focused, often issue is with the parents not children (Nodia Marshall, Spring Leaf Solutions)
- e. It is one thing to treat the kids but they go back home. Kids can be more supported if we support families. (Judith Rose- Wilson, AMH)
- Connect with residential schools. Kids have drug use and mental health issues. They have already been identified as high risk. (Dr. Senora Simpson, BHPC)
- DBH comes in on the back end to monitor but we need to get in before then. The coordination is key. (Dr. Marc Dalton, DBH)
- We have security guards and police officers in schools that doesn't know how to handle mental health. We need to look at the things that really worked and bring them back. (Dr. Senora Simpson, BHPC)

**Q5: We have brilliance within our system. How do we identify gems and jewels and get knowledge out to community so we can bring good ideas to scale?**

- No response.

**Q6: Other comments?**

- There is not a provider directory on the DBH website for SUD, there is only one for MH. Can we get one up? (Judy Ashburn, Samaritan Inns)
- How many SUD programs for kids are out there? We have clients asking but unsure where to send them? (Nodia Marshall, Spring Leaf Solutions)
- What is the status of the revisions to Chapters 34 and 63? It has been so long since this process started.
- DBH should allow LPCs to provide the same services as Social Workers (especially for assessments) in order to utilize all available professionals. (Nodia Marshall, Spring Leaf Solutions)
- E-invoicing has been great, but there has been an issue in the past involving POs that span a fiscal year. The process should be faster. (Michele May, Deaf Reach)
- AHL has come a long way; there have been great improvements in AHL.
- This has been a good opportunity and shows Dr. Bazron really wants to listen. Everyone has something to say, and no matter what degree you have, you are not all knowing. (Dr. Senora Simpson, BHPC)
- *Dr. Bazron follow up:* Please send us (email Marina Soto) some gems and jewels. We need to identify good things happening. We can be isolated and we need to do more cross pollination
- Please attend the BHPC meeting, as we are the eyes and ears for Dr. Bazron (Dr. Senora Simpson, BHPC)

- *Dr. Bazron follow up:* We are an integrated MH/SUD system of care, and DBH is submitting the first combined MH/SABG Block Grant Application this year.

**6/26/19 Provider Listening Session Two at MBI (2041 Martin Luther King Jr. Ave., SE)**

**Attendees: 66 Total: 59 Providers from 11 Organizations; and 7 DBH Staff**

- Liliana Tatum, Clinical Director, District Healthcare Services
- Navid Daei, Program Director, Community Connections
- Maya Wells, Compliance Director, Neighbors Consejo
- W. Allen Pittinger-Dunham, Clinical Director, Inner City
- Alexis Harris, Clinical Director, Family Preservation
- Lewis Smith, PQI, Family Preservation
- Dawn Lewis, Clinical Supervisor, Global Resources & Supports
- Jerome Bates, Federal City Recovery
- Guy Starling, Clinical Director, Federal City Recovery
- Tara Jackson, Office Management, Federal City Recovery
- Lambert Mbom, Program Administrator, Holy Healthcare Services
- Shannon Johnson, Community Wellness Ventures
- Charlayne Hayling, PhD Clinical Director, Community Wellness Ventures
- Maurice Gross, Dreamers and Achievers
- Maria Henry, Dreamers and Achievers
- Jerry Fitzgerald, Dreamers and Achievers
- W. Cowles, Dreamers and Achievers
- Nina Drakeford
- Kevin McCain
- Rosalind Moise
- Henry E. Stelle
- Elisha Stanley, CC, MBI
- Sabina Sarkwa, QI Specialist, MBI
- Lauren Swank, Director QA/QI MBI
- Atiba Vheir, Clinical Manager, MBI
- Denise McNeal, Dreamers and Achievers
- Corinne Meijer: Director of Clinical Operations, MBI
- Mollie Hart, Clinical Director, MBI
- Melody Cooper, Peer Specialist, MBI
- Jennifer Franklin, Peer Specialist, MBI
- Theodore Noumy, Logistics, MBI
- Dorothy Adams, Executive Director, MBI
- Siobhan A. Gavins, Care Coordinator, MBI
- Lisa Rix, Associate Clinical Director-MLK, MBI
- Niquelle Jett, Wrap Around Care Coordinator, MBI
- Oumoul Cherif, Proposal Development Office, MBI
- James Lindsay, Proposal Development Office, MBI
- Reyna Rice, MST Program Manager, MBI
- T. Hill-Feltan, Clinical Manager, MBI
- J. Thomas, Children Care Coordinator, MBI
- I. C. Nnawuchi, Medical Director, MBI
- Vivian Lowell, HR Director, MBI
- Paula Hopson Stanley, HR Manager, MBI
- Dawn De Barros, Training Coordinator, MBI
- Alexis W DeSert, Clinical Manager, MBI
- Donna Lloyd-Manning, CC, MBI
- Robert Magoba, IT, MBI
- Jason Derago, MBI
- Rhonda Johnson, FSFSC



- Lynne Person, MBI
- J. Hayden, MBI
- Rosine Busoto, MBI
- Corinne Meyers, MBI
- Carlos Hunter, MBI
- Vincent Jones, MBI
- Dr. Marc Dalton, Chief Clinical Officer, DBH
- Kevin Martin, Network Development Specialist, DBH
- Laressa Poole, Manager, Network Development, DBH
- Tony Crews, MBI
- Merlin Fossi, MBI
- Sadiqa Long, MBI
- Jimmy Bost, MBI
- Robbyn Steiner MD, MBI
- Jennifer Cannistra, Director, Systems Transformation, DBH
- Raessa Singh, Policy and Programs Coordinator, DBH
- Annie Mogilnicki, DBH Intern, DBH

### **6/26/19 Overview Summary**

#### **Q1: Greatest Strengths of Current System of Care:**

- Growth of Certified Peer Specialists.
- Overall expansion of services.
- Provider CEOs are encouraging a “whole person” approach when serving consumers.

#### **Other comments during this question:**

- We need greater access points, to be able to do walk-ins.
- We should not limit peer specialists to one position or type of work.
- DBH should also develop a specific department for children and young adults.

#### **Q2: How do we do a better job at expanding and improving our services for young people?**

- Children should be able to go through substance use services as a family.
- The current funding structure does not acknowledge how difficult and expensive it is to work with children and families.
- There are many talented people who can work with kids who cannot meet the documentation requirement for audits, so providers ultimately need to fire them. There is a mismatch of expectations.
- Some children have missed receiving a screening before turning 18 (to qualify for DDS services) and fall through the gaps.
- We are dealing with children and youth in silos. Some work is done by schools, some by providers, and the work is not connected to each other.
- There is a workforce shortage, and we need solutions to recruit and maintain talent. It would help if all internships were paid.

#### **Q3: How do we integrate better, particularly in the context of “whole person” care?**

- We should allow for and incentivize one diagnostic assessment to cover both mental health and substance use disorders.
- We need more cross training on co-occurring conditions.
- It would help to have a well-advertised navigation tool or resource guide online.

**Q4: How do we bring agencies and information together so it does not look like we are only serving some of the population?**

- We should be bringing everyone in for a meeting to able to discuss increasing referrals amongst agencies.
- DBH should set up a data base that could include all information about a consumer; this would help agencies find hard to reach consumers.

**Q5: How can we showcase the innovative work providers do, so our providers get the credit they deserve?**

- DBH could start giving “shout outs” online. For example, MBI has a success corner on their website, and DBH could do the same.
- There isn’t anything in iCAMS that shows positive outcomes, it only shows what went wrong. There needs to also be a shift in how DBH thinks about outcomes (more positive).
- Clients and consumer should be able to call in to report success, not just failures.

**Q6: Other comments?**

- There is a gap between the cost of paying psychiatrists and the reimbursement that providers receive for psychiatry services. Agencies have to cover this gap, including by billing for other services like community support.
- It seems that DBH views the provider network negatively, and this view transfers to the public.
- It is confusing to work with multiple DBH staff; you can receive different or conflicting responses.
- DBH does not have a close pulse on the work being done by providers.
- Auditing
  - DBH has a “gotcha” mindset when it comes to audits.
  - Someone in AA views everything from a fraudulent mindset and assumes providers are always trying to commit fraud.
  - It would help for DBH to be clear about the “nice to have” standards that providers should try to meet and those “need to have” standards. It seems like some DBH standards exceed what is necessary.
- The FD-12 policy with DC police should be revisited.
- iCAMS
  - Sometimes DBH makes system changes, for example in iCAMS, but does not communicate these changes to providers. This can cause problems for providers. DBH needs to be clear when they change systems that providers use.
  - iCAMS has been down since yesterday; can DBH extend the deadline to submit weekly claims batches because of this delay?

**6/26/19 Detailed Notes**

*Dr. Bazron Introduction Comments:*

- Our goal is a recovery oriented system of care for people with SUD, mental health disorders, co-occurring disorders, and gambling addiction. Gambling addiction is important to include

because it affects the brain the same way substance use does, and people are negatively affected; for instance, they can lose their homes and families.

- We want to cover a few things today
  - What are the strengths of the system?
  - What are the challenges of the systems?
  - Where are the gems and jewels of the system? How do we celebrate and bring our successes to scale?

*Comment during introductions:* There are patients who are ready to move out of the hospital to get their own spaces. Patients should be able to live in their own space and then go to the hospital for day services. There is a new apartment complex (Park View) opening up near St. Elizabeths; can individuals leaving the hospital live here? (Kevin McCain)

**Q1: Greatest Strengths of Current System of Care:**

- Certified Peer Specialists: I am a certified peer specialist class of 2012. Under you Dr. Bazron it has grown, I want you to be able to utilize peer specialists more, to be able to extend the role to use the experience of people with lived experiences. People think certified specialists should start by working on ACT teams, but for some peer specialists working on ACT teams can be re-traumatizing. A better understanding of the role can help improve the system. Our lived experiences mean something. When I worked on an ACT team with Catholic Charities, it was re-traumatizing, and they didn't think I had the book knowledge so they didn't treat me the same. (Rhonda Johnson, FSFSC)
  - *Dr. Bazron follow up:* You shouldn't be pigeon holed into one position.
- Overall expansion of services: Adding new CSAs and expansion of services has been good, but smaller agencies need support to meet DBH's expectations and policies. They need closer support to be successful. (Dawn Lewis, Global Resources & Supports)
  - *Dr. Bazron follow up:* We want sustainability too; we've added 33 new providers (since May 2018).
- To piggy back on Peer Support Services. One of our peer specialists is now driving a car and used to be homeless. When he comes back to show us his new car, I tell clients our success stories, and it empowers them. To see successes from peers is much more valuable. (I. C. Nnawuchi, MBI)
- Linking new providers with DC Behavioral Health Association. We have a mission to serve everyone; encourage providers to be a part of the Association will increase success. (Liliana Tatum, District Healthcare Services)
  - *Dr. Bazron follow up:* We should be thinking about how we as a community support one another. Maybe a mentoring program can help with that.
- Greater access points, being able to do walk-ins. I believe the support DBH is providing in areas with the greatest need is a success. (Allen Pittinger-Dunham, Inner City)
  - *Dr. Bazron follow up:* We are expanding that; step one is utilizing agencies that are already referral entities who are certified to assessments.
- We were the recipient of grant, and we learned a lot about how to serve youth. We have been able to develop new interventions for 16-29 year olds but also want to note that as we expand services for youth, DBH should also develop specific department for youth (Navid Dae, Community Connections)

- We got a lot of information from SAMHSA. We started working with youth, hearing and listening to the youth, and we involved them in developing the program that works for them. We should be listening to them and learning about what works and what doesn't work. We have learned a lot. (Navid Dae, Community Connections)
- *Dr. Bazron follow up:* How do we export that knowledge so other agencies can use it? Should we have trainings to understand new alternative interventions? Sounds like you're saying we should put on a forum at DBH to have you share information.
- Many CEOs are encouraging providers to serve the consumer as an entire consumer; for example if they come in as a housing consumer, we are able to connect them to other services and agencies. We should be looking at the total person and also about families, for example ACT patients with children about to be removed. We should be thinking outside the box. (Possibly Denise McNeal, Dreamers and Achievers)
  - That reminds me of wrap around service. We look at the entire family (including physical health) and are able to involve the whole family. (Dawn Lewis, Global Resources & Supports)
- There are a variety of people coming in which is great. We have transportation--we encourage consumers to use MTM for transportation to programs. (Denise McNeal, Dreamers and Achievers)
- Are there forms or information about what we are doing about the issues?
  - *Dr. Bazron follow up:* You can visit [DBH's website](#) for the most updated strategic plan, which gives information and tracks progress on the opioids epidemic. We have seen fewer deaths but there are many factors to that.

**Q2: How do we do a better job at expanding and improving our services for young people?**

- Children should be able to go through substance use services as a family. If my children were able to receive services in the same place I was we would have all been able to move forward. (Rhonda Johnson, FSFSC)
- The funding structure doesn't acknowledge how difficult and more expensive it is to work with children and families. Workforce shortage is also an issue. There are many talented people who can work with kids who cannot meet the documentation requirement for audits, so they ultimately need to fire them. There is a mismatch of expectations. (Corinne Meijer, MBI)
- The problem with the workforce shortage is competitive reimbursements. There are services that are not being reimbursed adequately. The transition grant does cover some costs, but evidenced based practices require a higher rate. (Mollie Salpeter-Hart, MBI)
- You have children who have missed the screening before turning 18 years old (to qualify for DDS services). They aren't certified before 18 so they can't get services. Youth get caught in different programs but don't meet criteria to get the supports to navigate moving forward. (Alexis Harris, Family Preservation)
- A solution to the workforce shortage could be some sort of externship programs for licensed clinicians so they can be trained and stay. (Navid Dae, Community Connections)
  - If I had had a paid internship I'd be more valuable to organizations.
- DC One cards (which help ensure safety of kids) should be updated throughout the life of a child.
- Barriers are a systematic issue. We are dealing with children and youth in silos, when you have schools doing work and also another agency involved. There is a lack of connection

between the work and the lived environment of that child. You may have progress in one location but there is a lack of supports in the other, and we should be looking at the whole child. (Allen Pittinger-Dunham, Inner City)

- We need to support the EBPs that have been developed in the system. We need higher rates but also support for the workforce delivering the service. For example, we have to provide a ton of services just to be able to pay for the required supervision for the EBP, and it's a disincentive for people to do EBP because it's costing the agency. DBH could consider providing training for EBPs, so it doesn't become part of the fee-for-service. If we can bring DBH-sponsored trainings back, it could encourage the system to do more. (Marie Morilus-Black, MBI)
- Youth can be saturated with services and when they have multiple services, too many people are coming in and out of their home. CBI may be serving one child and another has other providers.
  - *Dr. Bazron follow up:* How do we pull it all together?
- I think the district has made progress in interagency work. (Corinne Meijer, MBI)
- There is a lot of attention on the opioid issue, and we shouldn't forget about substance use that may not be opioid use. In some cases when we try to talk about other issues they only want to talk about opioid. (Tony Crews, MBI)
  - *Dr. Bazron follow up:* More people die from alcohol use; we also have K2 and PCP, and cocaine is also on the rise. We don't have a prescription drug program here but we do have these other drugs.

### **Q3: How do we integrate better, particularly in the context of “whole person” care?**

*(Back in 2014 we placed substance use services and mental health services in the same umbrella but it's still parallel play)*

- I recently attended the PEW Foundation luncheon, and there was a lot of good info -- you indicated it is parallel, but if a client walks in the door and clinician is capable of diagnosing both, we should allow that one diagnostic assessment can cover both mental health and substance use treatment. It's hard for clients to start a 3 hour process at the ARC then go to another agency across town for another assessment before they can receive services. (Allen Pittinger-Dunham, Inner City)
- Can the assessment at PIW be our assessment? (Mollie Salpeter-Hart, MBI)
  - *Dr. Bazron follow up:* If you're certified you should be able to do an assessment.
- We need more cross training on co-occurring conditions; everyone should be trained to have a level of understanding of both, and be able to make linkages from expertise. Everyone should have the level of training for one entry. (Dawn Lewis, Global Resources and Supports)
  - *Dr. Bazron follow up:* Who agrees there should be mandatory cross training?  
*(Majority raises hands)*
- But, it depends on the reimbursements. If agencies know you can be paid for each assessment, they will do two. DBH needs to incentivize one assessment (I. C. Nnawuchi,)
  - *Dr. Bazron follow up:* We all agree we should be cross trained, what should be our implementation plans to do this?
    - There should be a needs assessment first to see what agencies are capable of operating at the right level; with that info, you can highlight those agencies

- and generate an internal drive for the other agencies to get to that level. (Allen Pittinger-Dunham, Inner City)
  - Use a train the trainer model. (Mollie Salpeter-Hart, MBI)
  - The IT system for MH and SUD should be the same; we should also have a care coordinator. The systems are complex, but it would help if we had a paid position to help clients navigate the system.
    - *Dr. Bazron follow up:* Should peers do that?
      - Yes
- For substance use services for children: There are some systemic problems, but a quick fix would be a navigation tool or resource guide. We all start from scratch. It takes a long time for people to get acclimated to DC, and then they have to learn about resources for each service and system (FSMHCs versus CSAs; Performant Supportive Housing versus Virginia Williams, etc.). It would help if DBH could create a centralized resource guide. (Charlayne Hayling, Community Wellness Ventures)
  - *Dr. Bazron follow up:* We had a tool online (Network of Care), and it was meant to help people navigate the system. It included geo-mapping and showed the list of services by area. How successful was the network of care site? Do we still have it? It's not utilized? (*response from group was "no"*)
    - There was a website that tried to do this, but it's not advertised. (Corinne Meijer, MBI)
    - Any online reference tool also needs to be integrated with phones.
    - The public defender's office has a helpful resources guide. (Corinne Meijer, MBI)
    - Any resource guide should include all the inpatient and outpatients clinics. There doesn't even need to be mapping. (Charlayne Hayling, Community Wellness Ventures)
    - Interfaith Council of Metropolitan Washington (<https://ifcmw.org/>) has a resource guide – it is a listing of everything offered in DC, VA, and MD. (Liliana Tatum, District HealthCare Services)
- All agencies should be integrated. (Alexis Harris, Family Preservation)

**Q4: How do we bring agencies and information together so it does not look like we are only serving some of the population?**

- Dr. Bazron: I am shocked by the number of people we've served. We have only served about 23,000 mental health consumers and 5,000 SUD clients last year, and something is missing. We need to do a better job. We are serving many people, but there are other people being served elsewhere who we aren't capturing, and there are people not being served who we should try to help.
- We should be bringing all providers (including MCOs and FSMHCs) in for a meeting to have a discussion about how to increase who we serve. (Mollie Salpeter-Hart, MBI)
  - *Dr. Bazron follow up:* How do we pull all these pieces together?
    - Use special needs cases as the building blocks, to consult with other professionals, and use those meetings to build integration. (Lewis Smith, Family Preservation)
      - *Dr. Bazron follow up:* Perhaps we could have something like consultation rounds, i.e. a meeting to discuss complex cases as a coordinated group.

- DBH should set up a data base so all information can be included in order to track consumers. For us it's an administrative cost to find people, and after 3-4 times providers often give up. Consumers/clients could be found if all of their information is in one database that all agencies could use together to find consumers. (Carlos Hunter, MBI)

**Q5: How can we showcase the innovative work providers do, so our providers get the credit they deserve?**

- We are a web based system: what's wrong with including shout outs online, like the Mayor does? (Allen Pittinger-Dunham, Inner City)
  - *Dr. Bazron follow up:* How do we get the information from providers?
    - Agencies need a contact person to give DBH that info.
  - MBI has a success corner on their site; we can share those success stories, and maybe DBH could have a similar success corner with a showcasing of agencies. (Marie Morilus-Black, MBI)
  - One thing that worked well in Baltimore was an electronic newsletter, which helped success stories be shared.
- There isn't anything in iCAMS that shows positive outcomes; it only shows what went wrong. There needs to also be a shift in how DBH thinks about outcomes. (Mollie Salpeter-Hart, MBI)
- Client or consumers should be able to write in or call in with their successes. They can not only report what isn't going well but what has been good. (Tony Crews, MBI)
  - *Dr. Bazron follow up:* Sometimes we don't know the impact of what we do. We recently had a staff member pass away, and I've heard all the ways he's impacted consumers' lives.
- (*Thanked Dr. Bazron for her leadership*) We will have our second Walk for Recovery this weekend. And we were trying to showcase agencies in the city. We shouldn't allow others cities to be the only ones we're talking about. (Rhonda Johnson, FSFSC)

**Q6: Other comments?**

- In DC, families are at 450% of the poverty level; everything is more expensive in DC, including psychiatry. There is a gap between the cost of psychiatry reimbursements (\$250/hour) and the reimbursement rate (\$170/hour). Agencies have to cover this gap, including by billing for other services like community support. (Marie Morilus-Black, MBI)
- DC has great providers. DBH's view of provider network is often negative, so the community also views providers negatively. DBH should look for the positives because you are looking for the negative. There are some bad apples, but the network is doing some really good work, and we are trying to enhance the quality of care. We need DBH to join in on that. (Marie Morilus-Black, MBI)
  - *Dr. Bazron follow up:* We are looking for concrete ways to do that.
- Improve the communication: If you're working with multiple people at DBH, it can get confusing; you can get different or conflicting information. We need consistent communication. (Alexis Harris, Family Preservation)
- DBH doesn't witness the work being done, only what goes wrong. DBH should visit agencies not only when there is a problem with that agency. (Lewis Smith, Family Preservation)

- There is only so many things we can regulate. We are paying out of pocket for people to be seen due to the gap in reimbursements (for example psychiatry). We do this because we are really in the work to help people. For DDS services, they follow the suggested reimbursement rates; if all providers did this for MHRS/SUD services, it would be better. (Charlayne Hayling, Community Wellness Ventures)
- There is also an administrative burden—DBH has so many provider meetings, providers have to pay for required trainings, etc.
- What is DBH doing with Telemedicine? (Liliana Tatum, District Healthcare Services)
  - *Dr. Bazron follow up:* This is something we should be doing; the philosophy has been that it isn't needed in the city, but we should explore it and ensure we are using it to the greatest potential.
    - What are the requirements for using telemedicine now? (Liliana Tatum, District Healthcare Services)
      - You have to be on the site, its limited in how you're able to be reimbursed for it. (Mollie Salpeter-Hart, MBI)
      - *Dr. Bazron follow up:* Due to the land size, in MD we used telemedicine a lot. As you can imagine, it was hard to recruit psychiatrists, so telemedicine helped with access.
- One issue we have related to reimbursement rates is that we don't get paid when consumers miss appointments. In the private setting they would be charged, but we can't do that so we need to raise the rates to make up the difference. (Liliana Tatum, District Healthcare Services)
  - *Dr. Bazron follow up:* You mean to look at the rate structure.
  - Virtual waiting rooms through telemedicine could help with that; it's not used in this city but used in others. (Corinne Meijer, MBI)
- We need to improve information amongst clinicians; is there a system where you can put in the consumer and see what they've been attached to? (Shannon Johnson, Community Wellness Ventures)
  - *Dr. Bazron follow up:* That is an HIE issue; most of the HIEs won't do it for SUD due to permissions (i.e. 42 CFR). They'd have to get permission from every person at every annual appointment. We have to work on it, i.e. CRISP; how can we figure this out?
- Consistent Communication: We need a system to notify providers when a consumer has been hospitalized. Access Helpline used to notify providers, but this is not consistent. There is also no central database. DBH has a "gotcha" mindset when it comes to audits. It would be more helpful if they talk with us and work with us, and be realistic about the capacity of everyone's system. (Mollie Salpeter-Hart, MBI)
- There is an individual in accreditation who views things from a fraud basis; that person assumes everything is an attempt at fraud. His delivery of information makes providers not want to go to the meetings. (Allen Pittinger-Dunham, Inner City)
- I bring this up for Skip, who couldn't be here - iCAMS has been down since yesterday, how do we do our batch billing? Is DBH going to give us another 24 hours, because this notice came out at 3pm yesterday? (Allen Pittinger-Dunham, Inner City)
  - *Dr. Bazron follow up:* Yes, I will look into this as soon as I am back at the office. This is something we can fix.
- FD12: The policy with DC police should be revisited. We have reached out but didn't get response. We have an issue where police don't want to get involved or transport individuals



to CPEP. They will make up reasons why they can't transport. They've been called to nursing homes with violent patients, and they still won't take patients. They will arrive and then leave. In one instance they were called about a violent patient, and the police refused to take him. He ended up killing another patient with a fire extinguisher. We need to bring people together to figure out a solution to this issue. Also, within the IT systems, you can't tell if someone has been at CPEP. (I. C. Nnawuchi, MBI)

- There are forensic issues like this to talk about; we started a dialog with Dr. Johnson but it didn't go anywhere. (Marie Morilus-Black, MBI)
  - We've had a nurse practitioner have their nose broken by a consumer. (I. C. Nnawuchi, MBI)
  - We've had fewer FD12 trainings available; we need more. (Marie Morilus-Black, MBI)
  - Police may come but police don't want to follow through with transportation and creates barriers to treatment. (Alexis Harris, Family Preservation)
  - *Dr. Bazron follow up:* We can work with Dr. Dalton to address these issues. He will follow up.
- This dialog was encouraging; I appreciated the conversation about a single point for assessments. I think iCAMS and DataWits separates SUD programs within our network of service providers. Also, we don't have anywhere to send people who aren't suited for our services that have predominant mental health issues; however this dialogue is encouraging and has been helpful. We would definitely like to have access to network wide resources so we could refer consumers to other agencies. (Guy Starling, Federal City Recovery)
  - We are trying to get rid of paper and move to electronic systems but need more support. (Lewis Smith, Family Preservation)
  - Sometimes DBH make systems changes (like in iCAMS) but don't tell us, and then we don't have access to the information we need and used to be able to access. We need to know before systems changes are made, and we need to know what any implications for our workflow will be. (Alexis Harris, Family Preservation)
  - What standards are must haves and which ones are "nice to have"? It would be helpful for those who do auditing to understand what is actually required versus what is just nice to have. It feels like the standards exceeds what is actually required by law, regulation, and/or policy. (Corinne Meijer, MBI)
  - Shortage of clinicians- I'd like to see a meeting with providers to discuss incentives that DBH can assist with to attract and retain work force. The issues are getting larger. (Vivian Lowell, MBI)
  - Providers can't run a report to see all the consumers/clients who are linked to them. They used to be able to do this. We really need this capability again. (Corinne Meijer, MBI)

**7/10/19 Provider Listening Session Three at RAP (1949 4th St., NE. Washington, DC 20002)**

**Attendees: 16 Total: 11 Providers from 7 Organizations, and 5 DBH Staff**

- Michael Pickering, Executive Director, RAP
- Melina Afzal, Deputy Director, RAP
- David Storcks, Marketing, RAP
- Eban Ebai, CEO, Kinara Health Care
- Nisha Tracy, Clinical Director, Clean and Sober Streets
- Elizabeth Garrison, Chief Compliance, Quality & Evaluation, SOME
- Julia Lightfoot, Executive Director, Clean and Sober Streets
- Joyce Drumming, Administrative Officer, Life Stride
- Jacqueline Williams, Clinical Director, Absolute Healthcare
- Corey Odol, Director of Business Development, PIW
- Dania O'Connor, CEO, PIW
- Bruce Tisdale, Manager, Network Development, DBH
- Marsha Parker, Specialist, Network Development, DBH
- Jennifer Cannistra, Director, Systems Transformation, DBH
- Raessa Singh, Policy and Programs Coordinator, DBH
- Annie Mogilnicki, DBH Intern, DBH

**7/10/19 Overview Summary**

**Q1: How do we do a better job of expanding and improving our services for young people?**

- We need to make sure there are programs embedded in schools to reduce no shows.
- We need an electronic referral system for children.
- We need a snap-shot of which providers have availability and what services are available in our system.
- Shortage of staff is an issue. There may need to be studies on the capacity in the city and on whether or not our rates are structured to retain qualified staff.

**Q2: How do we integrate better, particularly in the context of “whole person” care?**

- We should move to auto-enrollment in MCOs and assigned navigators at hospitals.
- In regards to staff training, DBH should be thinking of training CSWs and getting them licensed to reduce fraud.
- When we moved from two agencies to one, we just moved the silos under one roof.
- Consumers are looking for a one-stop shop, a more centralized place where they can access both MHRS and SUD services.
- Access is an issue, and just relying on one or two institutions for SUD assessments is not sufficient.
- There is not a service model to fit people in pre-contemplation.
- There is no alignment or agreement within our system that SUD is not separate from behavioral health disorders. There needs to be a shared definition and understanding of what integration means.

- There needs to be unified treatment planning, one treatment plan for each person.
- People within DBH have to be trained for SUD treatment.

**Q3: Greatest Strengths of the Current System of Care:**

- SOME has pre and post-residential program where housing and services are available to people moving through levels of care.
- Clean and Sober Streets has integrated evidence-based practice into their therapies.
- RAP has been able to hire CACs who are in recovery themselves to offer an integrated peer specialist model.
- PIW has established alliances and MOUs with partners to help eliminate gaps in service once people leave PIW to transition to the next level of care.

**Q4: How do we enhance the quality of care in our system?**

- Offer more trainings that award CEUs, are given in the evenings, are given by content experts, and are reimbursed or paid for.
- DBH can offer direction to the network on how to address provider burnout.
- Build in supervision and administrative work into the rate structure to create an administrative overhead rate.

**Q5: Other comments?**

- We need an electronic central information hub to know what kinds of services are available and how to make connections to those services. This should also include SUD services.
- There should be a central location for communications from DBH about new initiatives and programs.
- There needs to be technology to support data on quality and to allow providers to generate reports that they can use as a case management tool.

**7/10/19 Detailed Notes**

**Q1: How do we do a better job of expanding and improving our services for young people?**

- It seems like there are many organizations engaged in this work, but each organization is doing things a different way. We need to make sure there are programs embedded in schools, especially in wards that may lack access, so that children get the services they need. We need an electronic referral system for children. There should be a system like CRISP to allow for referrals. There is a system that allows providers to talk to each and include PHI. (Corey Odol, PIW)
  - *Dr. Bazron follow up:* There are barriers around 42CFR, so how do we get the right data?
    - SOME participates in a qualified business service agreement, and they can share protected data within a set of providers who are all in the service agreement. A contractor was working with DCPCA on this issue and the recommendations were sent to Matt Caspari. It seems like under the umbrella of SUD providers, it should be straightforward to share data. (Elizabeth Garrison, SOME)
    - *Dr. Bazron follow up:* In CRISP, we know sharing PHI requires affirmative consent annually, CRISP has decided they can't take on the responsibility of getting approvals to share PHI.
- Do providers daily submit what their openings are? (Dania O'Connor, PIW)

- *Dr. Bazron follow up:* No, but this could be done through a “bed board;” communities across the country are doing this.
  - DC hospital association was doing it, there were fragments of this model happening now. (Elizabeth Garrison, SOME)
  - Is this done through access helpline? (Liz Wolfe, Mary’s Center)
    - *Dr. Bazron follow up:* No, AHL does a lot of things, but this bed board would be in real-time.
- Could DBH give a snap shot of what’s available without passing info about a patient? (Dania O’Connor, PIW)
  - *Dr. Bazron follow up:* We were exploring this bed board idea and whether we could use a voice activation system, like an automated call.
- In CRFs we are looking for a referral system that is centralized and fluid, and not wanting to overwhelm access helpline. This needs to be centralized and electronic but not just Access Helpline, and not the ARC. (Melina Afzal, RAP)
- It isn’t just about access, it is also about and shortage of staff. There may need to have studies on the capacity in the city and on whether or not our rates are structured to retain qualified staff. In Chapter 34, psychiatrist rates are bundled with nursing services, which works well for nursing facilities but otherwise leads to specialty rates not aligning with care. There needs to be unbundled rate. (Elizabeth Garrison, SOME)
- One big issue are how no-show impact the rates. The current rates would support services if people showed up, but when they don’t we lose money. (Joyce Drumming, Life Stride)
- MHRS rates are lower for similar services; we aren’t factoring in overhead. People lose money on psychiatry services because it’s hard to staff. (Elizabeth Garrison, SOME)
- We had to stop doing services due to funding issues from the no show rate. You can’t change a no show rate. (Dania O’Connor, PIW)
  - *Dr. Bazron follow up:* How can we address the no show rate?
    - Previously in the area, we got together and attached recreation centers to schools. It’s a natural place for children to go. (Joyce Drumming, Life Stride)
    - To address no show rate, we keep services in the school setting. If you can control the location, your show rate increases. (Dania O’Connor, PIW)
      - *Dr. Bazron follow up:* Doing this in child development center will also help with that; the Healthy Futures program got money from the Council and can expand these services.
    - These services should be in after school programs as well, not just in the classroom. (Joyce Drumming, Life Stride)

**Q2: How do we integrate the system better, particularly in the context of “whole person” care?**

- In MD people are enrolled in MCOs; in the District, there are fewer people enrolled. Those enrolled receive case management and wrap around services. Without that, residents don’t know how to access services and fall through the gaps. In MD you are assigned a navigator when you’re enrolled in MCOs, but in the District you have to choose an MCO. You get a form in the mail but many residents are transient and get lost in that system. We should move to auto-enrollment and assigned navigators at hospitals. We have difficulty treating patients after they leave PIW; they end up being re-hospitalized. If there are navigators assigned at hospitals, the ROI would be 20 fold in the reduction in readmissions. (Corey Odol, PIW)

- When we moved from two agencies (separate MH and SUD) to one, we just moved the silos under one roof. We actually created a conflict between SUD and MHRS, which is frustrating from a provider's perspective because when we go to DBH for TA the person might be MHRS instead of SUD. Staff needs to have a mindset and training for system-wide integration. (Michael Pickering, RAP)
- Consumers are tired of running around to access services, they are looking for a one-stop-shop, a more centralized place where they could access both services. We are running the clients around, and it has to do with the referral platform. They can't just go to one place. Transportation is a problem, just getting them to each location for assessments is a barrier. (Joyce Drumming, Life Stride)
  - *Dr. Bazron follow up:* We have a co-occurring code in the system, but it isn't billed. How do we support a provider community address co-occurring services?
    - In Chapter 34, anyone with MHRS can walk in anywhere and get an assessment, this isn't the case for SUD. (Joyce Drumming, Life Stride)
    - We need an integrated electronic health system. (Melina Afzal, RAP) )
      - Access is an issue, just relying on one or two institutions for assessments isn't sufficient. (Elizabeth Garrison SOME)
      - There needs to be a change to the culture, we have to work first to get the people providing the services and the people regulating the services to understand integration. (Julia Lightfoot, Clean & Sober Streets)
      - How does DBH coordinate with DC Health, especially their work around opioids? There is a break in that integration. How are other states or countries doing integration? (Melina Afzal, RAP)
    - *Dr. Bazron follow up:* In Maryland, The Primary Care Project is a program that has recruited 85% of primary care physicians to do behavioral health assessments and have peers attached to the practices to walk people through the system. Doctors are paid to do these assessments in a value-based payment methodology.
- In regards to staff training, DBH should be thinking of training CSWs and getting them licensed to reduce fraud. If they are given a license, they will be more accountable for their work. (Eban Ebai, Kinara)
  - *Dr. Bazron follow up:* What should the approach be to do that?
    - DBH should develop a curriculum or an online training and then require CSWs to pass certification, like they do in other places. (Eban Ebai, Kinara)
    - There is a DLA 20 tool in MD, for CSWs. (Jacqueline Williams, Absolute Healthcare)
    - CACs need a certification, we may want to replicate that and include mental health and substance use. We should look in to what they did. (Joyce Drumming, Life Stride)
    - *Dr. Bazron follow up:* We developed a framework for a CSW training, we could resurrect some of that work done by Erica Van Buren to see if it makes sense.
- Returning to the one-stop-shop idea, we do have a warm handover process, and many of the behavioral health centers have a warm handover process. For example, La Clinica is one, from medical and dental for instance. But there is still a big hurdle to allow clients to be able to bill for SUD services in those cases. There is no way to do community-based SUD services. For example, if I see my primary care provider and he notices signs of drug use, I would talk to social worker, she would do a brief intervention, and it can be billed. But if she

is trying to do an SUD brief treatment, there isn't a way to bill for that. There isn't a service model to fit people in pre-contemplation. (Elizabeth Garrison, SOME)

- There need to be interventions to keep people coming back that doesn't involve a 2-hour intervention/assessment. There might to people who will have some conversations but don't have a court order or aren't ready to enter treatment today. We need to make services the least restrictive and most accessible they can be. We need person-centered and community-based care with the ability to bring services to the client. (Elizabeth Garrison, SOME)
- I love the mobile crisis program, can we consider putting something in to expand SUD services at a beginning to help initiate services, to be able to do a warm hand-off to services? (Joyce Drumming, Life Stride)
  - *Dr. Bazron follow up:* That is what the Community Response Team is supposed to be doing, engaging with people who are in that pre-contemplative stage. The connection to services when they are ready for them is a big piece.
- Before the merger, it felt like there was more support of SUD services and now it's more about stabilizing clients with mental health issues. The challenge we face is the stabilization of those clients when they come in for SUD treatment. Sometimes it might be 30 days before they can receive or benefit from SUD treatments. You don't want different tracks for MHRS and SUD because it isolates the services. (Julia Lightfoot, Clean and Sober Streets)
- Sometimes ACT referrals go through immediately, and sometimes we get no response and don't know the status. That seems like an area that could be improved. (Liz Wolfe, Mary's Center)
- PIW has worked with a lot of people to coordinate care; the number one issue is there is not alignment or agreement within our system that SUD is not separate from behavioral health disorders. If there was first a set decision on that belief then integration would be expected. The thought seemed to have been to just put the two departments together but there wasn't a confirmed belief system established about integration of care. (Dania O'Conner, PIW)
  - We throw these terms out a lot but there needs to be a system-wide definition of ASAM and person-centered care. Since we've been held to ASAM there has only been one DBH training and you could only send one staff member, and there where a limited number of seats. People from the ARC weren't even in the room. (Michael Pickering, RAP)
  - *Dr. Bazron follow up:* We need system wide definitions but also need to know what are the expectations, what is our agreement on what this means and what it looks like in real life.
- You'll never get integration until we have a unified treatment planning, one treatment plan for each person. We use DataWits as the fall guy (for lack of integration), but we should also look at unified treatment planning. According to SAMHSA's levels of integration, level 6 is one integrated system. DataWits is hard to use, cumbersome and obsolete. It doesn't support data driven decision making. (Elizabeth Garrison, SOME)
  - *Dr. Bazron follow up:* We have five different systems, and we to need look at that.
- When SUD came over there was an assumption that everyone at DBH knew about substance use treatment, but they didn't, and it was never addressed. People have to be trained for SUD treatment. (Joyce Drumming, Life Stride)
  - *Dr. Bazron follow up:* Training should be a priority, what we need to do to make sure providers send their staff to training? How do we get around taking people out of service?
    - Offer CEUs. (Elizabeth Garrison, SOME)

- Tie trainings to reimbursement or licensure, and offer more time/date options. (Dania O’Conner, PIW)
- Offer evening trainings. (Elizabeth Garrison, SOME)
- Be reasonable about the length of training in relationship to the topic. Not all topics need all day or two-day trainings. For example, CAFAS training should not be two days. (Liz Wolfe, St. Mary Center)
- Ensure trainings are done by people with a background in substance abuse, make sure they have content expertise. (Julia Lightfoot, Clean and Sober Streets)

### **Q3: Greatest Strengths of the Current System of Care:**

- We implement Vivitrol, which is a strength, but if we had a standing protocol for re-authorization for 10 days you could positively affect warm hand-offs and coordination of care. (Corey Odol, PIW)
- We are able to offer a pre and post-residential program where housing is available and services are available to people moving through levels of care, including crisis beds. (Elizabeth Garrison, SOME)
- We have integrated evidence-based practice into our therapies to include art, acupuncture, yoga, and other varieties of therapies to give consumers more outlets and options. (Julia Lightfoot, Clean and Sober Streets)
- We’ve been able to hire CACs who are in recovery themselves to offer an integrated peer specialist model. (Melina Afzal, RAP)
- PIW has implemented an agreement to make sure medical needs are tracked and addressed. We’ve established alliances and MOUs so we don’t have gaps as people leave their programs. We saw that once people left PIW, they didn’t make it to the next program/organization, so we make sure people come to the facilities to explain their programs, and consumers get help to the next level of care. These partners are doing these presentations and services for free. (Dania O’Connor, PIW)
  - *Dr. Bazron follow up:* In-reach activities, where they come in to the facility to reach consumers.

### **Q4: How do we enhance the quality of care in our system?**

- More trainings. (Michael Pickering, RAP)
- Look at provider burnout. We have high burn out and due to billing and caseloads, we don’t have time to come together as a group to address staff burn out, so getting some direction from DBH on how to avoid burn out would be helpful. (Liz Wolfe, St Mary Center)
- We need a rate structure that allows for support staff for clinical staff, and to build in administrative overhead. (Michael Pickering RAP)
- Build in supervision into rate structure. We used to get 3% of the total HCA to cover administrative costs and supervision, and now that’s not in place. That rate helped to ensure the quality of services. (Joyce Drumming, Life Stride)
  - *Dr. Bazron follow up:* If there was some sort of administrative overhead rate, would that address some of these issues?
    - *Majority response:* Yes
  - You’re holding us to requirements you don’t pay for. (Joyce Drumming, Life Stride)

### **Q5: Other comments?**

- It is not clear where a person should be placed. Which need is more important? Housing, medical, SUD? Having an electronic central information hub around what kinds of services are available and knowing how to make those connections would be helpful. (Nisha Tracy, Clean and Sober Streets)
  - *Dr. Bazron follow up:* We have Network of Care, is it helpful?
    - *Mixed response from the room, heads shaking yes and no*
    - SUD providers aren't there. (Michael Pickering, RAP)
- I think there needs to be improvement in communication. I love that mobile crisis is 24/7 but I hadn't heard it before. Having a central location for communications about things like that. For example, I've heard, Howard Road is now offering walk-in services, but didn't hear it from DBH. (Liz Wolfe, Mary Center)
  - *Dr. Bazron follow up:* Yes, Mosaic is implementing it through a contract that DBH has through the hospital association to get us upstream. They can do peer support, induction, and peers follow them for a set time. What this speaks to is needing a 1 pager on the new and innovative programs and how to connect with them.
- DCPCA has been working on a central referral system and a social determinants of health model ([DC PACT](#)), there should be collaboration with DBH on that. (Elizabeth Garrison, SOME)
- There needs to be technology to support quality data; there should reports generated that you can use as a case management tool, and DataWits doesn't do that. (Elizabeth Garrison, SOME)

**7/25/19 Provider Listening Session Four at Holy Comforter (124 15th Street SE. Washington, DC 20002)**

**Attendees: 16 Total: 12 Provider from 9 Organizations and 4 DBH Staff**

- Alicia Sellitti, Therapist, Life Stride
- Michelle Cook, CEO, Life Stride
- David Shrank, Life Stride
- Teesa Banks, CEO, Family Solutions of Ohio
- Amina Hall, Clinical Director, Family Solutions of Ohio
- Marcus Smith, Executive Director and Clinical Director, Calvary
- Tonia Gore, Behavioral Health Planning Council
- Betty Gentle, Policy, SOME
- Janice Gordon, CEO, Holy Comforter Community Action Group
- Ann Chauvin, CEO/Executive Director, Woodley House
- Dalton Beckles, Director, Amazing Love
- Dr. Ivan Walks, CEO, Integrated Health Resources
- Samantha Slater, QA, New Living
- Joycelyn Allen, Specialist, Network Development, DBH
- Venida Hamilton, Director, Network Development, DBH
- Jennifer Cannistra, Director, Systems Transformation, DBH
- Raessa Singh, Policy and Programs Coordinator, DBH



**7/25/19 Overview Summary**

**Q1: How do we move towards service integration?**

- There needs to be a fully integrated EMR.
- We need to move away from the individual model and move towards a family model.
- People that go into the community to provide services need to be trained and confident in their intervention techniques to address issues like addiction, trauma, and sex trafficking.
- There needs to be more training for all professionals to address co-occurring diseases and expand integrated assessment and treatment.
- Utilize data driven decision to focus on the “so what,” not just the “how many.”
- We need quality and accurate assessments done by the ARC to ensure referral to correct level of care.
- Offer CEUs for trainings.

**Q2: How do we do a better job of expanding and improving our services for young people?**

- There is a tool but not a payment structure to encourage the proper assessment of children and family-focused treatment. The Child and Adolescent Functional Assessment Scale (CAFAS), implemented properly, can assess, but that becomes secondary when you have fee-for-service model.
- We should educate parents to recognize the signs of first-episode psychosis earlier.
- If there was more flexible funding, providers could attract more qualified staff. For instance, CSWs might not always be the most qualified to serve in schools.
- We should look at what areas have more overdoses, where addiction rates are higher and respond to those areas accordingly.
- To address workforce shortages, you can look at temporary, permanent, or specific opportunities to change qualification requirements to reduce barriers.
- All child services should be time limited to reduce dependence on those supports.

**Q3: What do you think is needed to support providers over time?**

- Providers that take too long to follow up internally with the client, which goes back to management of their organization.
- If wait times were related to people waiting for a preferred provider, can we learn why people like that provider and replicate what they are doing well?
- If one provider doesn't have an opening, they should be able to refer the consumer to another provider. Increasing networking, or the creation of an online portal or bedboard might help with that.
- Competition is an issue. Because each agency has to have a set number of people and roles, they have to share professionals. Everyone is spread so thin across providers.
- If a provider can be certified by Medicaid but cannot meet the requirements for DBH, we should look at how we need to improve the network and not compromise the quality of care.
- If we move away from fee-for-service there might be an opportunity to be able do our jobs at the level needed.

- Access Helpline might be a barrier as well because people can't go directly to the provider.

**Q4: What are gems and jewels in our system that you think we should bring to scale?**

- There should be a newsletter again.
- There should be a “welcome to DC” resource. There are a lot of people and staff from other places, and they don't know how to navigate our system.
- The police are trying to establish a more positive rapport between police and community.
- Managed Care Organizations (MCOs), supported by Medicaid, are helping people by paying for supportive housing and are seeing positive results in terms of health outcomes.
- Having access to someone at a higher level in the organization, like the Director, is helpful when looking at reducing silos.
- There have been positive interactions with individuals from DBH's new Community Response Team (CRT); a woman from CRT called needing someone to get services right away, and it was a good interaction.
- These listening sessions have been good, and the peer specialist program is good.
- There are some MCOs that look at the whole person, offering things like free gym members, which can help with anxiety and stress.
- People from other states, or who have private insurance, don't get the services our consumers get. DC has great services.

**Q5: Other comments?**

- Life Stride's housing liaison has gotten a lot of people and families housed.
- There used to be a 3% overhead for administrative tasks. Reinstating that can help address some of the issues mentioned.

**7/25/19 Detailed Notes**

**Q1: How do we move towards service integration?**

- Having a shared electronic medical record (EMR) is important; ICAMS is great but not everyone is fully integrated, they have to opt in. (Michelle Cook, Life Stride)
- People who are going into the community need to be better trained and be able to intervene where interventions are needed, and bring family-based services back to the community. (David Shrank, Life Stride)
  - *Dr. Bazron follow up:* We need to move away from the individual model and move to a family model, and do more around community engagement.
    - We need to do more around training. People that go into the community to provide services need to be trained on addition, trauma, and sex trafficking. And not only trained but they need to feel comfortable with the actual interventions. (David Shrank, Life Stride)
      - *Dr. Bazron follow up:* The need the ability to really utilize that skill set.
    - They need to know the culture. (Tonia Gore, BHPC)
  - There needs to be more training. People are treated by a CAC or a therapist, and they don't integrate the training, and don't have the SUD background. They should all be able

to address all parts of the person's life. People have to go to a separate place for SUD and MHRS, we need to have one place where they can be assessed for both. (Teesa Banks, Family Solutions)

- *Dr. Bazron follow up:* It's hard to find professionals who are able to do both but you're talking about an integrated dual diagnosis treatment model, where all professionals can assess and refer. And in an enhanced model, they can assess, refer, and treat.
- Outreach workers need to be more representative of the communities they treat. (Betty Gentle, SOME)
  - *Dr. Bazron follow up:* We want the people doing the outreach to look like the people that are there. We also need to understand what is most acceptable to the community? While that might be case for some communities, it is not for Asian Americans because of shame. But we need to look at what the community wants.
- We should be always looking at the outcome. Where are we trying to get to, what are trying to achieve, and how can we create a system to reach those outcomes. Maybe that's something like value-based payment but it not a concern about how we will get paid--it's about what is the best outcome for that person. And being able to use peers, for both MHRS and SUD, and make sure they are integrated into that care system, that is who is going to reach the people that are using. (Ann Chauvin, Woodley House)
  - *Dr. Bazron follow up:* You're talking about when data driven decision gets a voice, but I haven't seen it realized yet. I am hearing we have to be focused on the "so what," not just the how many. What have we done to make a difference in the life of the person and what does that metric look like.
- On the SUD side, one issue we see is that when someone goes to the ARC for assessment, they may not be assessed properly. When they get to us we realize we have to move them to a higher level of treatment. They aren't coming to us assessed properly. (Marcus Smith, Calvary)
  - *Dr. Bazron follow up:* The level of care is a mismatch, what's your recommendation?
    - Everyone is using ASAM criteria, and there was as training, but there weren't very many representatives from ARC at the training. Those are the people need to be trained to do a good quality first assessment. (Marcus Smith, Calvary)
      - Can they be reassessed? (Amina Hall, Family Solutions)
      - *Dr. Bazron follow up:* We don't want the person to have to go through that again.
      - Why are you doing a second assessment? (Teesa Banks, Family Solutions)
        - We see different information and need to reassess. (Marcus Smith, Calvary)
- On the clinical side, I suggest we offer CEUs for trainings. Otherwise we have to send staff to another training for those CEUs. (Amina Hall, Family Solutions)

**Q2: How do we do a better job of expanding and improving our services for young people?**

- We need to know what we are working towards, and having data related to those services and the goals would be helpful. The CAFAS implemented properly could do that, but that

becomes secondary when you have a fee-for-service model, so I think it's a structural issue. The people that are funding the programs aren't clinical; they are motivated differently. (Samantha Slater, New Living)

- *Dr. Bazron follow up:* Is it all about money?
  - Yes, that's the problem with all programs, but for children in particular. (Samantha Slater, New Living)
- *Dr. Bazron follow up:* You're saying the rate structure doesn't support quality care.
- You can't do family-focused interventions with the rate structure. (Amina Hall, Family Solutions)
- You have to be able to work with the parents to treat children. (Teesa Banks, Family Solutions)
- *Dr. Dalton follow up:* CAFAS will not capture the info?
  - *Dr. Bazron follow up:* No, the tool is fine but the financial model supersedes the assessment. It's not a tool issue, it's a financial issue.
- I think there is a cultural basis for how providers are doing the services. For instance, the person doing the CAFAS is not the person doing the services in the community. You have community perceptions affecting how people are interacting with providers. There are systematic issues that affect someone's likelihood to use services. (David Shrank, Life Stride)
  - *Dr. Bazron follow up:* I hear three things, 1) whether or not the assessor is the service deliverer – it might be the same and it might be different. 2) Stigma is an issue, are people willing to receive the service? and 3) community context and how we are using that context should be considered when deciding how we do the service.
- At St. Elizabeths, in their intake process, parents will say they recognized warning signs but didn't know they were warning signs until their child was an adult. How do we educate parents to recognize those signs earlier? (Tonia Gore, BHPC)
  - *Dr. Bazron follow up:* I hear you saying we need to get upstream and make sure information is out there so parents can identify if someone is having an early break. We need to use the episode psychosis set-aside from the Mental Health Block Grant to do some of those things.
- We need to know what areas have more overdoses, where addiction rates are higher and respond accordingly. (David Shrank, Life Stride)
  - *Dr. Bazron follow up:* Yes, we have geo mapping.
- If we were able to obtain more flexible funding we could attract more qualified staff; CSWs might not always be the most qualified to serve in schools. (Samantha Slater, New Living)
  - *Dr. Bazron follow up:* How do we expand the workforce? It's hard to find LICSWs. I am looking for an addictionologist, someone trained in addiction and board certified, but they are hard to find. This is a nation-wide problem. What are your ideas?
    - I am an LPC, I have clinical training, but LPCs don't have the same ability to diagnosis, DC could expand that. (Samantha Slater, New Living)
    - *Dr. Dalton follow up:* Because we are a metro center, the appearance is that we have more clinicians.

- From a system perspective, from a leadership perspective, we need to look at the barriers. For instance, nurses in Maryland couldn't practice in DC, and we looked at that to allow them to practice here. Other things you can do is to look at temporary, permanent, or specific opportunities to change requirements to reduce barriers. You can look behind instead of looking in front. If someone can do the job, let them do it, and it can be a conversation about how to remove barriers. The other thing is to find a way to consider passion. Is this something you really want to do? When those people are in the community, they know and are able to connect. Maybe they don't have the license, but they can connect to the community, that can also improve compliance. (Dr. Ivan Walks, Integrated Health Resources)
- You hit the nail on the head, especially when talking about people who have competence but not passion. When you start removing things they can do, it creates burdens for a provider, but it also communicates to the staff that they aren't worthy or capable. When you allow people to be in jobs they are passionate about, over time, it creates loyalty. It allows us to move beyond the clinical stuff, and we can offer more services that connect to the community and add more content to services. (Janice Gordon, CAG)
- All child services should be time limited. No person should be in services their entire lives. Otherwise their services becomes their natural support, and they gain dependence on those supports. (Dalton Beckles, Amazing Love)
  - Like in addiction, there are limits. (Janice Gordon, CAG)
  - There is an expectation that staff is supposed to do everything for the person, rather than focusing on their recovery and building natural supports. (Dalton Beckles, Amazing Love)

**Q3: What do you think is needed to support providers over time?**

- How were determinations made about what was needed to serve consumers? (Janice Gordon, CAG)
  - *Dr. Bazron follow up:* It came up during the hearing, people were testifying about being waitlisted and that services were not available in Wards 7 and 8.
  - I've had clients come in and say their wait for a psychiatrist was a month, or they had not connected to a CSW for months. (Teesa Banks, Family Solutions)
  - *Dr. Dalton follow up:* For MHRS, once they get in, people complain about the wait to see a professional. For SUD there were complaints about the wait for certain levels of care.
- I don't think there is an issue about people getting in to be seen, I think there are providers that take too long to follow up internally with the client. And it's harder due to gentrification because it reduces the number of clients. It's about being able to handle the clients in the appropriate amount of time, and it goes back to management of the organization. (David Shrank, Life Stride)
  - *Dr. Bazron follow up:* It is a quality of care issue.
- I was surprised there are 33 new providers, I just have more questions. I understand the issue with getting in to see a psychiatrist in a CSA, but I wonder, was there a waitlist for a preferred service agency? Were they requesting a specific provider and couldn't get in?

If it was an issue of them wanting a preferred provider, can we learn why people like them, and replicate what they are doing well? (Ann Chauvin, Woodley House)

- We just learned that there are 33 new providers, there seems to be lack of communication amongst providers. If we don't have room, we should be able to refer them to someone else that we have that relationship with. Maybe increasing networking, is there some sort of online portal to see what everyone is doing? (Alicia Sellitti, Life Stride)
  - *Dr. Bazron follow up:* This reminds me of how Maryland works, the funding goes into the CSA and then funnels to the needs of the community. They then develop a provider network tailored to meet the needs of the community. The other issue of the bedboard is how do we have an electronic way to know where the vacancies are in the system are, and then be able to put people in the right place.
- Competition is an issue. People are trying to get their money back, and it is a very competitive by nature. Because each agency has to have a set number of people and roles, we have to share professionals. Everyone is spread so thin across providers. We need to look at competition across the system. Competition is degrading the system. (Teesa Banks, Family Solutions)
- If the ultimate goal is good service, then some of these requirements are a bit onerous for new agencies. When you have to have something like a full time CFO, in other businesses they will just get those services as they need them but for providers, they have to have one full time CFO, and that's hard. If I have an agency, and I can be certified by Medicaid but I can't meet the requirements for DBH, we should look at how we need to improve the network and not compromise the quality of care. (Dr. Ivan Walks, Integrated Health Resources)
  - *Dr. Bazron follow up:* Maybe mini networks might be something to explore because in that model, you're all related, you can reduce competition because you can share resources like a CEO. Maybe are aren't getting to all the people because we are thinking more about the structure instead of serving people.
- I think there should be a mandatory year of doing quarterly meetings to explain all the process amongst providers. Amazing Love didn't have anyone to go to in order to figure out next steps, and having that partnership would be helpful. I think we miss the essence of the work, we went to school and did all this work in order to provide good quality service, and I think that is lost in DC. The top need is housing, and we have to be mindful that clinicians are dealing with all of these unmet needs. If I did the quality of work the clients need, we couldn't afford it. If we move away from fee-for-service, there might be an opportunity to be able do our jobs at the level needed. (Dalton Beckles, Amazing Love)
  - *Dr. Bazron follow up:* I can tell you we are a looking at things like fee-for-reporting and performance.
- Access Helpline might be a barrier as well. People can't go directly to the provider, I think just opening that up so the consumers have the freedom to get services could help. (Michelle Cook, CEO, Life Stride)
  - *Dr. Bazron follow up:* They can go directly to provider.
    - But they still need to get the approval at some point and tell their stories again. (Michelle Cook, CEO, Life Stride)
  - They don't tell their story, they just give their information and then give their stories to the provider after they are connected. (Tonia Gore, BHPC)

- I've found that depends on who you get; some people ask more questions. I tried to link someone, but once we were on the phone with Access Helpline, they were asking a bunch of questions and the person left. (Samantha Slater, New Living)
- Sometimes it doesn't take a lot for something to be a barrier, we have to meet them where they are. (Michelle Cook, CEO, Life Stride)

**Q4: What are gems and jewels in our system that you think we should bring to scale?**

- There used to be a newsletter; I think that should come back. (Dalton Beckles, Amazing Love)
  - *Dr. Bazron follow up:* We were talking about this morning; we are going to bring back DC Connect.
- I think there should be a provider “Welcome to DC” packet; there are a lot of people from other places, and they don't know how to navigate our system. And there are staff that don't know about the system. (Dalton Beckles, Amazing Love)
  - *Dr. Bazron follow up:* Have you seen the access piece online that tells you how to access the system?
    - I have but it's not helpful for consumers. (Dalton Beckles, Amazing Love)
- I'd like to note how the police are trying to integrate a more positive rapport between police and community. (David Shrank, Life Stride)
- MCOs, supported by Medicaid, are supporting people with supportive housing and are seeing positive results in terms of health outcomes. MCOs are paying for it and are reducing readmission and hospital visits. (Ann Chauvin, Woodley House)
  - *Dr. Bazron follow up:* Housing is a reoccurring cost, so is it indefinite?
  - They are doing this as a transition service, and then sometimes they go into the coordinated entry system, but they are paying for transitional housing. (Ann Chauvin, Woodley House)
- There was a meeting looking across the country at system design, primarily focused on military families, but they are looking at breaking down silos. They are using science, research, and best practices that gives credibility to system design. One point that came out is that at some point people need to be high enough in the system to make the changes needed to reduce the silos. Having access to someone like you, who is able to make changes, is a big deal. (Dr. Ivan Walks, Integrated Health Resources)
- When we were the 13<sup>th</sup> street facility, we changed our population from all female to male and female, and the council member called me. Because we had been there for so long we had relationships so it wasn't an unfriendly discussion. When we opened this building, we met with this community, and it was very contentious and unfriendly. All they saw was drug addicts. Over the past few years, we've brought in the ANC and engaged in a lot of communications; we've had to do a lot of community engagement. (Janice Gordon, CAG)
  - *Dr. Bazron follow up:* We need an approach to community engagement; you've learned some lessons that you can pass along to others.
- I look at behavioral health through the lenses of policies, something in place is the Interagency Council on Homelessness, and we would like to see a strong partnership with DBH. As we are evaluating the plan, racial equity has come up, and substance use has come up as something to address. (Betty Gentle, SOME)

- I had a positive interaction with someone from DBH’s new Community Response Team (CRT), she called needing someone to get services right away, and it was a good interaction. (Samantha Slater, New Living)
- These listening sessions have been good. I’ve been to two, this one and one with Consumer and Family Affairs Administration, and the peer specialist program is good.
  - *Dr. Bazron follow up:* I think peers are a gem, but I think we have to be thoughtful about their role responsibilities. In other places peers are given responsibilities that go either above or below what they should be doing. It is great to have that experience but we have to be very intentional and thoughtful about that role. And when I talk to people with lived experience they want to know what their job is, and they want to be paid appropriately.
- Last week I attended a meeting with the president of Howard and we talked about how the university can assist residents in ward 7 and 8. We talked about the university tracking trauma from gentrification, and how having access to data like that can be help to understand residents. They collected data from patients at Howard, asking questions to track their experience and be able to make correlations with gentrification. Also, there isn’t a big social media presence. We talked about parents not having information about first-episode psychosis; we should use social media to change that. (Marcus Smith, Calvary)
- We are excited about telemedicine and look forward to partnering with DBH on that. (Amina Hall, Family Solutions)
  - *Dr. Dalton follow up:* Yes, we have a van that has Wi-Fi and can ingrate that.
  - *Dr. Bazron follow up:* Is Family Solutions doing telemedicine now?
    - We are hoping to get there. (Amina Hall, Family Solutions)
- There are some MCOs that look at the whole person; they are offering benefits like free gym members, which can help with anxiety and stress. They offer free transportation to appointments, and it’s been a big help. (Teesa Banks, Family Solutions)
  - *Dr. Bazron follow up:* Is that AmeriHealth?
    - Yes, they provide free bicycles, gym members, etc. They address the whole person. Some people are just choosing plans, but they don’t know how to choose the right one for them. (Teesa Banks, Family Solutions)
- We have been doing a lot work with RN support. (Michelle Cook, Life Stride)
  - *Dr. Bazron follow up:* Blending and integrating physical health with mental health is critical.
- I hear from people who come into my office and say that DC has good services. People from other states, or who have private insurance, don’t get the services our consumers get. We have great services. (Alicia Sellitti, Life Stride)

#### **Q5: Other comments?**

- A brief gem, our housing liaison has gotten a lot of people housed and has gotten families in to stable housing. (David Shrank, Life Stride)
- A lot of what we talked about boils down to finances. There used to be a 3% overhead for administrative tasks. That could help address some of these issues. (Michelle Cook, Life Stride)