NEW YORK STATE DEPARTMENT OF HEALTH
PUBLIC HEALTH AND HEALTH PLANNING COUNCIL
HEALTH PLANNING COMMITTEE
REDUCING EMERGENCY DEPARTMENT BOARDERS: BEHAVIORAL HEALTH PATIENTS WORKGROUP
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1:00PM – 3:00PM
VIA ZOOM

Dr. Rugge I'll start by introducing myself. I'm John Rugge. I'm here as Chair of the Planning Committee of PHHPC, the Public Health and Health Planning Council for New York State. I think as everybody knows, we are here because a few months ago the State Emergency Medical Services Council brought to the Department of Health concerns about long delays in offloading abundances in emergency departments in various places around the state, sometimes requesting the squads to wait for hours in the parking lot. This concern led the Department of Health and the persons of Commissioner McDonald, Dr. Morley and Dr. Heslin to approach and bring these issues to PHHPC for consideration, for consultation, for help. At the same time, undertook very serious studies and research and digging deep into the nature of the problems recently and in the past. Big surprise. What this led to very quickly was realizing it's not just a problem at the E.R ramp. Any problems with offloading have to do with overload of the E.R. itself in terms of boarding in the hallways as a consequence of inpatient crowding, in part due to inability to discharge patients to an appropriate home setting or to long term care settings because of stressors and those parts of the health care system. We are left with the system stressed that instead of concern everywhere. As we initially met, we realized PHHPC was under a challenge for these last two years of not being able to meet in person because of COVID and had these series of Zoom meetings. That waiver has gone away, but we learned in the course of time that by bringing ourselves together on a short notice in this kind of way has real value. Instead of meeting in person. We're meeting as a work group not to make decisions, but to bring ideas, thoughts and knowledge to build for our help. In doing that, realized a very appropriate first place to start is by addressing behavioral health problems leading to on board and issues and system crowding. Because mental health is everywhere. The issues are extremely complex. Very significant work is underway by the Office of Mental Health. We have the advantage of resources that we very much need. As I see it, this coming together of the Department of Health with the Office of Mental Health has implications. That is we don't have a department problem, we have a system problem, but we also have a government looking at how to solve these issues, which is very important and very good sign of hope. Here we are together trying to establish our future. In doing that, we'll start by having the members of the council who are here introducing themselves just saying very briefly in a minute or so what the experience is they're bringing and the perspectives they are bringing to this meeting.

Dr. Rugge I'll start by saying I'm John Rugge. I'm a family physician, have been the organizer over forty some years of a network of community health centers that is now delivering primary care to half the population in a rural area the size of Connecticut. What I know is there's been a lot of change over that period of time. My suspicion is that change is only going to become all the more important and all the more speedy.

Dr. Rugge With that, I know Jeff Kraut is planning to attend as Chair of the council.

Dr. Rugge Is he here?

Dr. Rugge I don't know that I see him.

Dr. Rugge We'll come back to Jeff.

Dr. Rugge Ann Monroe, Vice Chair of the Planning Committee.

Ann Monroe Hi, everybody. I'm Ann Monroe and as John said, Vice Chair of the Planning Committee and a member of PHHPC. I am a consumer member as appointed to PHHPC and have as a perspective primarily the patient and the consumer of the health care system. That's what you'll hear me weighing in on. Thank you for all being here today.

Dr. Rugge Sabina Lim. Dr. Lim, I think you were here.

Dr. Lim Sabina Lim. I'm currently the system VP of Behavioral Safety and Quality and Medical Director of Government affairs. Essentially what that means, I focus not exclusively, but a lot on behavioral health safety, quality policy, regulatory issues. Before that, I ran for about eight years or more the behavioral health service scene at Mt. Sinai, which is one of the largest behavioral service lines in the city. Before that, I was actually several years at Connecticut, at Yale, New Haven, and basically had different positions running the clinical behavioral health services there too. Happy to join and happy to see folks.

Dr. Rugge Thanks for joining us.

Dr. Rugge Moving along, Dr. Soffel, Denise Soffel?

Dr. Soffel Good afternoon. Denise Soffel. I am a longtime Medicaid Consumer Advocate here in New York State, the other consumer representative to the PHHPC. Like Ann Monroe, you will be hearing from me from articulating the concerns of and the realities of what life looks like from the patient perspective.

Dr. Rugge Very good.

Dr. Rugge Dr. Strange. Ted Strange. I think I've seen you here, too.

Dr. Strange I'm here. Ted Strange. I'm the Chair of Medicine at Staten Island University Hospital and also a Western Region Leader for the Northwell Health System as an Associate Regional Physician Executive, obviously, we see a lot of the issues that you brought up this morning as it relates to overcrowding in the EDs. We're in a place on Staten Island of about 500,000 people, which could be the 30th or the 31st largest city, if it were a city unto itself with no public city hospital, believe it or not, even though the charter says that there's supposed to be city hospitals in all five boroughs. We essentially take care of all the needs of all the patients of Staten Island. We do have a smaller hospital, Rumsey, that does provide some care here. Despite two relatively new emergency rooms with the bigger services continue to see overcrowding and patients coming in. Our indigent population isn't as difficult as some of the other boroughs, but we are beginning to see some immigrant and cultural shifts and changes here on Staten Island also, and that tends to put some stresses on us. Of course, as you said, the behavioral health side, we have a very, very big issue on Staten Island, both of child health psychiatry and adult health psychiatry that's been trying to be addressed. Northwell has been a great partner for us to help us get through some of these issues, but I think this is a great, just pertinent

discussion that needs to occur and we need to come to some conclusion. Thank you for putting this together.

Dr. Rugge Thank you.

Dr. Rugge Dr. Yang.

Dr. Yang Patsy Yang. I'm currently Senior Vice President at New York City Health and Hospitals. I have been at health departments in Westchester and New York City Health and Mental Hygiene within health and hospitals at Metropolitan at Bellevue, and currently heading up Correctional Health Services, which is the health care provider for everyone in the city's custody on Rikers and in the Bronx. I represent, I guess, a provider patient advocate. We all are. Our current patient population and as a provider, a relatively small number, I think, but with particularly challenging issues for the system.

Dr. Rugge Thank you.

Dr. Rugge Peter Robinson.

Peter Robinson Hello. Dr. Rugge. Peter Robinson, member of the council, Chair of the Establishment and Project Review Committee, longtime health care administration down in the city at Bellevue and Columbia Presbyterian. Obviously, for a long time now at the University of Rochester Medical Center in the Finger Lakes region of Upstate New York. We are addressing issues that are probably state wide problems, but I think we are experiencing some of these acutely in the Finger Lakes region. They do tie into significant issues around behavioral health, especially as it relates to children who are in need of long term care environments, be they outpatient or inpatient and that's lacking but significant emergency room overcrowding, hospitals that are running over census and shortages of long term care beds because of understaffing that create alternate level of care problems in the hospitals that are significant combined and I'm sure this is true statewide, but the economics of health care in New York are really under water in most places. They certainly are in Upstate New York. That has been because levels of funding are flat or only slightly up, but the costs of care, whether they are workforce or otherwise, continue to go up at much more dramatic rates. Workforce shortages, high cost of workforce are also factors here that we need to address. Again, thank you, Dr. Rugge and the department for convening this meeting.

Dr. Rugge Very important observations. We can't solve everything at once, but we can start someplace and ambulance ramp seems to be as good as any.

Dr. Rugge Kevin Watkins, nice to have you join us.

Dr. Rugge Dr. Watkins.

Dr. Watkins Thank you, Dr. Rugge.

Dr. Watkins It's a pleasure to be here. I am Kevin Watkins. I am a member of the council. I am currently working as a Public Health Director for Cattaraugus County Health Department. I've been in that capacity for about thirteen years so far. I am representing, I guess, the rural community and public health overall. As you will know, in the rural community here, we also experience a lot of workforce shortage. We have one hospital in our community. We are always seeing a potential deficit every year. The hospital is in a

red. It has been taken over by one of the largest conglomerate hospitals in Buffalo. We have a lot of concerns here about the health care system that's being delivered in a rural community. It'll would be interesting to have this conversation with all of you and hopefully I can give my perspective as well.

Dr. Rugge We are here for all the good reasons, which is every reason. By my lights and my look there's one more member of the council attending who has a very deep interest and concern and lots of energy on this. That would be Jim McDonald, who also happens to be our Health Commissioner.

Dr. McDonald Dr. McDonald.

Dr. McDonald Thank you. Dr. Rugge.

Dr. McDonald I'm Dr. Jim McDonald, the Acting Commissioner of the New York State Department of Health. Very interested in what I'm going to learn today. I've really learned a lot already. It's always good to hear from you. I am not going to say a whole lot more at this point because I want to hear your ideas.

Dr. McDonald I'll turn it back to you, Dr. Rugge.

Dr. McDonald Thank you so much.

Dr. Rugge We're counting on you for sure.

Dr. Rugge Let me see where we go next.

Dr. Yang Dr. Rugge, we have one more council member.

Dr. Rugge Who was that?

Dr. Rugge Harvey, good for you.

Dr. Rugge Harvey, can you introduce yourself and expand your background and your perspective?

Harvey Lawrence Harvey Lawrence, a member of the council. I am the President and CEO of a FQHC serving Brownsville in East New York and Brooklyn. We are also supported by safety net hospitals in this area, many of them that have been challenged financially as well as being challenged with their E.R. Emergency Department access and overrun with the volume of services and the need for services in those departments. I am acutely aware of the workforce issues because those issues are things that we are struggling with that we have not struggled with at the level that we struggle with ever before in terms of commissions as well as nurses. With regard to behavioral health, it is incredibly difficult to identify service providers. We are on the front line as many FQHCs across the state are. We get to manage through this workforce dilemma. I don't know where the salvation or solutions going to come from, but it is one that I think has major, major challenges for the delivery system, presents major challenges.

Dr. Rugge Trying to begin to find those solutions exactly why we're all here.

Dr. Rugge Thank you.

Dr. Rugge Next by way of introductions, we need someone to describe and introduce the Health Department members who are here.

Dr. Rugge John Morley, how about starting with you?

Dr. Morley I'd be happy to start. John Morley, the Deputy Commissioner for the Office of Primary Care and Health Systems Management. I've got close to fifteen years in government service and ten years in DOH service between two different tours of duty. I'm looking forward to this project about as much as I've ever looked forward to any project.

Dr. Morley Let me turn to our deputy chief of staff next.

Maclain Berhaupt Hi, everyone. Maclain Berhaupt. Nice to meet all of you. I've been at the department now for seven months or so, but my background has been working with the support of housing Community for over twelve years. I have a a strong interest and connection to behavioral health. I'm really excited to continue the conversation around how our hospitals and health care systems can connect with the behavioral health side and how we can support each other. I really look forward to working with all of you and learning more today.

Dr. Morley Dr. Heslin.

Dr. Heslin Dr. Heslin, first Deputy Commissioner, Chief Medical Officer. I've been with the department for about six years now. Family practitioner by training, twenty-five actually thirty years in practice still see patients. Thank you.

Karen Madden Hi, everyone. I'm Karen Madden. I'm the Director of the Center for Health Care Policy and Resource Development in the Office of Primary Care and Health Systems Management. That's the center that where we're the rural health programs are all of the workforce programs and OPCHSM policy and regulations.

Dr. Morley Thank you, Jackie.

Jackie Sheltry Hey, everyone. I'm Jackie Sheltry. I'm the Director of the Office of Policy and Standards within OPCHSM.

Dr. Morley Thank you.

Carrie Roseamelia Hi. I'm Carrie Roseamelia. I'm the newest member working under Karen Madden as the Director of the Workforce Innovation Center.

Dr. Morley Can you just say that one more time just because your're so new and it's so important.

Carrie Roseamelia Sure.

Carrie Roseamelia I'm the newest employee here. Working with Dr. Morley, Dr. Heslin, and working under Karen Madden as the Workforce Innovation Center Director.

Dr. Morley Thank you.

Dr. Morley We've been talking about this for a while, and now we actually have a Director for the Center for Workforce Innovation.

Dr. Morley Thank you, Carrie.

Carrie Roseamelia Thank you.

Dr. Morley Jennifer.

Jennifer Treacy Hi, everyone. I'm Jennifer Treacy. I am Dr. Morley's Deputy Director. I've been with the department for twenty-eight years. I am a pharmacist by clinical training.

Dr. Morley I think that might be it for DOH.

Dr. Morley If there's someone else from DOH I've missed.

Dr. Morley Sir, turn it back to you, Dr. Rugge.

Dr. Rugge Thank you very much.

Dr. Rugge I will turn it over to someone who needs no introduction Ann Sullivan is Director Commissioner of Mental Health and Long Term Service to the State of New York.

Dr. Rugge If you, Ann, could describe your approach to all of this and also introduce members of your team.

Dr. Sullivan Good afternoon, everyone. It's a real pleasure to be here. First of all, I'll be going into the details later during the presentation, but we have probably the most robust commitment to mental health that I've ever seen in the State of New York. Governor Hochul has committed $1,000,000,000 to mental health. When we prepared this plan with the Governor a big piece of it is to address issues that I know we're going to talk today, which are the issues that are posed in emergency room submissions, the unit upon discharge. To be quite frank, I think some of the problems that we have had with the seriously mentally ill since the institutionalization, which was like forty, fifty, sixty years ago that we never fixed in terms of the breadth of community services that are needed. We really have a jumpstart for that at this point in time. I'll be talking about all that later. As I present it, I think it's very important to hear back from you how you think we should be implementing systems all across the state. We're meeting with groups all across the state. We have a blueprint which I will be describing to you, but the devil is in the details and in how we work within communities to make sure that these services really, really work and how we connect, especially with the hospital systems. I think that that's going to be a very, very critical point as we roll out what I hope I think you'll appreciate is a wealth of services that we've never had the opportunity before. I think if we do it right to make a real difference. I also have to say that before this job I worked for twenty-five years at Elmhurst and Queens hospitals in Queens. I understand the pressures of hospitals. I know what EDs are like. I was the network director for a while, so I know what medical emergency rooms are like. A lot of what we're trying to put in place is to leave that pressure, but also to do the right thing, the right thing by individuals. I think the only person I have, actually, I think Chris Smith from OMH is here. He's our Associate Commissioner for Community Based Services, cause a couple of my team were pulled away suddenly to deal with something having to do with a bit of a crisis in New York City. They're down there instead of on screen. Chris is here.

Dr. Sullivan Chris, you want to say hello?

Chris Smith Good afternoon. I'm Chris Smith. As Dr. Sullivan said I'm the Associate Commissioner for Adult Community Care with statewide responsibility for adult community service program development. Prior to my years in OMH both in New York City and now in Central Office, I also have a strong hospital background with the Bellevue for a number of years and before that at the Zucker Hillside Hospital within the Northwell system. Also excited about all the opportunities we have right now to develop new resources and bring them together to better support transitions in care, support hospitals and support community providers in strengthening the mental health and behavioral health care system.

Dr. Rugge I see also we've been joined by the Chair of the council, the Chair of PHHPC. Jeff Kraut is here.

Dr. Rugge Jeff, you want to say a few words about your background and your perspective.

Jeff Kraut I'm Jeff Kraut. I have the privilege to Chair the council. I spend most of my time whatever time is available, other than the council working for Northwell as Head of Strategy. I think just really appreciate everybody getting together to deal with what is an importantissue. I want to welcome our alumnus, Dr. Sullivan, who we served together for many, many years. It's always good to see you.

Dr. Rugge Also participating in very important ways, as Dr. Sullivan has suggested are the representatives of our hospital associations across the state. These households being at the center of care for sure, but also an inspiration and a center for the change we need to make it as a health care world and delivery system.

Dr. Rugge Could you all introduce yourselves and just say what organization you're representing?

Sarah DuVall Hi. My name is Sarah DuVall. I'm the Director for Behavioral Health at the Health Care Association of New York State at HANYS. We have a behavioral health task force that leads a lot of our initiatives there. One of the initiatives are complex case discharge delays. We've done extensive work on that.

Wendy Darwell Wendy Darwell. I'm the CEO of the Suburban Hospital Alliance, which represents hospitals on Long Island and the Hudson Valley.

Dr. Kerwin This is Kevin Kerwin with the Iroquois Health Care Association. We're a regional association representing fifty or so hospitals and health systems in Upstate New York. Really, I can't underscore Dr. Watkins and Mr. Robinson's comments enough very important points that they made.

Alison Burke Alison Burke with the Greater New York Hospital Association. I'm a Vice President and the point person for behavioral health issues. I will say also for prehospital care, EMS issues. I have both hats and hear from both sides what's sort of going on. I sit on the State Emergency Medical Service Council as well. I do have one colleague here with me, Scott Gaffney, if you would, just introduce yourself.

Scott Gaffney Hi, everyone. This is Scott Gaffney. I'm the Assistant Vice President of Health Economics and Finance at Greater New York and support Alison on a lot of the behavioral health issues. We're looking forward to the discussion today. Thank you.

Dr. Rugge Thank you to all the participants. I would also note that this meeting has been posted for the public and the observers are very welcome and more than that, encouraged to submit any comments to Colleen Leonard. They will be sure to be distributed to all of us. This has to be a communal effort. As we move forward, we'll begin to share our perspectives and also look for opportunities for further research and digging in so that we can learn what kind of successes, what kind of financial or regulatory or other reforms have been underway, either successfully or not elsewhere for us to learn from. With all of those challenges before us, if you look to the agenda, you'll see we're doing a problem summary, starting with Dr. Morley and then moving to Dr. Sullivan about E.R. overcrowding in general and then the special challenges posed by mental health conditions and behavioral health problems.

Dr. Rugge Dr. Morley.

Dr. Morley Thank you, Dr. Rugge.

Dr. Morley Dr. Rugge had summarized the situation pretty well. I'm just going to add to it. It didn't happen overnight. It isn't going to get resolved overnight. Despite the fact that everybody knows the staffing challenges we have, I still think that we still think that there are opportunities here. I think the opportunities present perhaps without additional staffing. We're going to try and chip away at this a little piece at a time. It's going to take some time and it's going to take some effort, but the cause is worthwhile. The fact that the ED overcrowding issue has gotten to the point that it's impacting ton EMS and EMS response times...not everyplace, but in many places is substantial. It tells us that the problem continues to worsen. At a minimum, what we would like to achieve is that we reduce the speed at which it's accelerating, the speed at which the changes have been occurring in the wrong direction and begin to slowly reverse them.

Dr. Morley Dr. Sullivan, you want to add on?

Dr. Sullivan I'm not sure exactly, Dr. Rugge, how you want to do this. We have a lot of resources that have been in this current budget, which I could go through. It would take a little time, but it might just help inform at least where we're coming from in trying to help the problem. I don't know if you want me to do that now.

Dr. Rugge What challenges are you seeing being posed by the population you're serving and then also a review of this current landscape, what existing programs have you put in place to ease the boarding? What more do you see going is next steps? We will have everybody join in, including in addition, the last two people have joined us, but we'll get to them too.

Dr. Rugge Ann, the floor is yours.

Dr. Sullivan I was thinking about this, you know, and I think when we talk, we've talked a lot to hospitals and providers across the state. I think there are three issues that come up thatcontribute boarding. I think the first one is getting the right kind of assessments. Making sure that you have a staff who can do that assessment and come up with the right treatment at the time or disposition if someone's leaving the ED. I think in terms of helping

with the assessment phenomena, I think telehealth is going through hospitals and is very helpful in terms of being able to provide consultations from psychiatrists, from practitioners, from others, social workers to really come up with what's a reasonably good assessment. I think if we use that really well you can get a good assessment. You can kind of know pretty much what the next step, most appropriate next step would be. What's the next step? I think that's where we get into a lot of issues. A lot of patients get treated very well very quickly. We have some very complex cases. I think the nature of the complex patients are usually individuals who have either diagnosis often and often have to do a diagnosis that is developmental disabilities plus mental health are the ones that I think are particularly problematic for EDs are individuals who've lost wherever their safe place to be was. They now are either homeless. Whatever service they may need as a place to go isn't really like it should be. Their diagnosis can differ. I mean,everything from the serious concerns of the homeless, mentally ill to individuals who are in a crisis, but whose families can't deal with them during a crisis, etc. The patient populations cover all the diagnoses, all the issues, but they're complex and they're difficult. Now, the second sticking point is two things, I think. One, the assessment done and the assessment says, I think this person needs a bed. Are there beds? The first question is, is there an easy access which should be there for patients to go to beds? We had our moments prior to the pandemic where things would get very clogged up and sometimes individuals, but on a big scale, general occupancy psychiatric business prior to the pandemic was about 70% to 72% across the state. Post the pandemic, the occupancy was in the high 80's to low 90's across the state. Now, that's two factors. One probably is an increased demand. Often with mental health there is an increased demand post something like a pandemic. The other were those closed beds. 1,500 or so closed during the pandemic. 850 stayed offline until early this year. The number of community based psychiatric beds across the state is somewhere about 6,000. When you pull out 850 beds you're pulling out a significant amount of availability for patients. That included kid beds but mostly adult beds. One good push for the administration last year was increase the rates for those beds and then also to demand those beds come back online. We're working with all the hospitals across the state. I have to say the hospitals have working very well with us to try to get those beds online. By the end of the year we should be close. 200 have come back. Over 200. We're probably going to get close to another 200 back by the end of this year and then some others going through next year. There's still some sticking points with some hospital systems, which I won't go into which we will be working very hard to make happen. This is a bit something I need to emphasize. There's a bit of a culture. Therefore, when hospitals are distressed the psych beds are in jeopardy. I think we really need to look at that. When you talk about paradigm, what we pay for is an interesting phenomenon. We have beds that make big margins. We have beds that make small margins. Sometimes we have beds that make some margins, maybe sometimes lose some money. How we designed that is up to people much beyond my pay grade. It really doesn't always speak to what's needed in the community. What's needed right now, as you are all experiencing are psychiatric beds. I think we have to come up with that solution and increase the rates. We've also worked tremendously. We need feedback from hospitals if this isn't working on medical necessity criteria on decreasing the amount of managed care. We need to hear if that's not working. We need to hear about denials if that's happening because with medical necessity criteria there shouldn't be denial. Now, you're also going to say that sometimes patients don't need to be there. They're waiting. I'll get to that. In terms of the basic care, I think that we are also working very closely with trying to make sure that that's appropriate. The hospitals aren't getting strapped with unnecessary denials and dollars for psychiatric beds. We need to know that that's happening. The other piece of that is also when we say rates go up, we up the rates for medical service, but we don't control the rate for managed care companies. We very much suggest that hospitals never accept anything below a rate.

Basically, if you are doing more, if you give more, that gets negotiated. Truthfully, that still exists sometimes in New York State. Very few people ever sign a contract for anything below a rate. I would just suggest again, that this needs to be really thought out in terms of making up those rates that that happens in order to get the payments that you deserve. We also have some capital for new beds. Now, I know you're going to say up the margin. The reality here is that we do have capital for new beds. Some systems have approached us, especially child beds. We're very excited about that about that. About over a year and a half ago we upped the rates for child beds. That's the bed situation in a nutshell of what we're pushing for to get the other beds open and to help anyone with capital who may want to add beds.

Peter Robinson Dr. Sullivan, can I ask a question about the bed issue?

Dr. Sullivan Sure.

Peter Robinson When you're thinking about those, I mean, sometimes the lines between OMH and I apologize OMRDD or whatever it's called now, but it's in essence, a significant behavioral health as well as developmental disability issue. Kids, particularly, who are in need of institutional slots, I don't know what the statewide issue is, but I believe that at least in our region, that is a major blockage. That backs up patients in hospital EDs, where those kids do not belong after they've been evaluated and readied for appropriate transfer.

Dr. Sullivan Absolutely.

Dr. Sullivan One of the things we've been working very closely with OPWDD on, and I think with some of the new dollars in terms of residential availability and what we consider housing for kids, but would be residential capacity for kids. So, for example, Baker Victory, Upstate is a step down unit for individuals with developmental disabilities and a mental health problem. It's primarily towards the dual diagnosis. That's been pretty successful, not 100%, but pretty successful in accepting kids and moving them on to really a very good placement afterwards, which avoids any long term institutionalization. We developed the model. That's something we're going to be expanding in terms of having that. Also some transitional beds is something we've been talking to OPWDD about. Sometimes kids and families, they just need a little time away and intense work, but then they can go home. In terms of some of the new dollars, we're definitely talking about developing those. We know, especially on the developmental disability side, the dual diagnosis, that there's an issue with getting the right kind of setting as well as the right kind of treatment. The other is that we just put out an RFP for each what we call home based crisis intervention services. These are services with kids where you go and do very intensive in-home services for up to two three months, depending upon what the child and family needs right there in the home. Two RFPs went out for that that are specifically for individuals with dual developmental diagnosis and mental health. We're beginning to integrate those services in. We're also going to be doing a lot of training. It's going to take a while to get there. One of the biggest issues if I have to honest, I think, that the workforce isn't as well trained on either side, whether OPWDD or on the health care side or dealing with those complex kids and adults. We also have a specialized adult unit in New York City with the step down, which is run at Kings County. They've done a great job in terms of working with individuals with disabilities. We will be opening up a dual diagnosis with the kids at SUNY Upstate. If that works, we will probably try to do also one Downstate. There's a lot of work going on to kind of work with that particular population. It's a big issue. The other thing I forgot to mention is also 150 additional state beds. The state beds. Some of those are child beds and some of them will be adult. Those will beds that should open up. There's been a

certain backlog in taking some individuals into the system who really need to come. Those will be specialized beds we'll be putting up. That's an additional 150 new beds in the state system that have not been there before.

Dr. Sullivan Any other questions?

Ann Monroe I have one.

Ann Monroe You said the first step and I can see why it's such an important step is the assessment. Who's licensed, credentialed, whatever, to do such an assessment? Are you facing a workforce shortage if that level of provider?

Dr. Sullivan Well, we've got a workforce shortage in everything just like everybody else does, a very serious workforce shortage. When we do an assessment in an ED, I think you really need... Someone comes to the emergency room usually it's a very serious issue. You need a level of expertise which is a licensed professional that has experience dealing with those kinds of crises. Sometimes you need a psychiatric, but you definitely at least need a psychologist or a social worker there to do a good assessment. If you have psychiatric staff in your setup that's great. Some hospital emergency rooms don't. What they've also been using is a consultation with telehealth with a psychiatrist or to be able to give that expert opinion as to what is needed. Telehealth gives you that capacity to access psychiatrists from the medical centers, from even private practices and companies. They can be there to assist. We now have the ability on the certificate, which enables you to transport someone to a psychiatric hospital. One of those to be done, which we do some of the stress on the emergency rooms. We did a pilot that was successful. Can do a lot with you if you don't have the qualified professionals on site. Many hospitals do and they just pull those individuals in to do the assessment.

Ann Monroe Thank you.

Dr. Heslin I have a question, Dr. Sullivan.

Dr. Heslin On that RFP for the home based crisis intervention services. Is that going to be Medicaid based? Is that going to also be commercial based? Because a lot of these kids may or may not actually be on Medicaid at that point in time and be commercial before they generate down. Is that just narrow? Is it going to go wide to all?

Dr. Sullivan Talk about mental health services and we fought for this one in the budget. Right now, home based crisis intervention is funded by the state. It's available.

Dr. Heslin It'll be available to anybody funded by the state, regardless of insurance. That is amazingly outstanding.

Dr. Sullivan It's fascinating. We still have pockets of services that are heavily funded by the state and that's one of them.

Dr. Heslin Fabulous.

Dr. Sullivan Basically, that will be available.

Dr. Sullivan The other very thorny issue, because this often also keeps individuals sitting in the emergency room are individuals who really don't meet the criteria for this and really

shouldn't be admitted but there's no place for them to go. This is where I'm really hopeful. We're going to have to work really closely with the hospital systems on this. We're setting up two things. One is 900 transitional beds across the state. A lot of those transitional beds should be linked to hospital systems for individuals who may need some time upon leaving an emergency room or an inpatient before they can transition into another level of psychiatric housing. We've got 3,500 beds coming up all together, plus supportive housing for that. A real infusion of housing, which is so, so critical for our clients. Because if you're homeless, everything else you try to do just doesn't work. You end up at a shelter. It's critical you have the housing. 900 beds will be transitional. Those transitional beds will help people both from emergency rooms and other settings. Very helpful, I think the emergency rooms. The second piece, though, is you can't just send someone somewhere because that doesn't work. We need to have a wraparound services. We're putting up across the state something for Critical Time Intervention. 50 of these across the state. A caseload of 80. Staff of about 12 staff. Those teams will come in and link right away with someone. They are very similar to the teams we've put up in the city on the street homeless. Doing a great job. I think they can do the same concept, work very well with emergency rooms. This is where we need your help. They should be able to come into the emergency room, meet the person, connect with the person, help the person get to wherever they're going and then be their support for up to a year. They don't disappear. They stay with them until they get to a steady state. Eventually, we're going to push to get them paid for by Medicaid and everybody else. Right now, these are being funded as well by the state. They're coming out. They have a tremendous amount of flexibility to work with what every client needs. We will be designing and will be working with them, county directors and systems that where we use these teams, they should be linked to emergency rooms and hospital discharges, because we know that that's where we've been losing clients. We have this revolving door where we have clients who can't leave where they're supposed to be. We also need the system to work with us. Fascinating. This morning, I was in a meeting with..he's now the.. he had done the Camden Project. They had little badges that the people wore that they were certified by something. The hospital saw that badge they knew it was okay for them to come in and see the client. Something similar to that might be something or any other way so that we have easy access to patch people and then work with them afterwards. I think there's a tremendous infusion of these. Some of you will say they lose money, but we gave a big increase. If we do it right and if we bill for everything they shouldn't lose money. Also by increasing them, we take some of the pressure off the other emergency rooms because they focus on psychiatric patients. We have the ability to put capital, which we've never had before, and start up to do a significant expansion across the state. Again, in regions where that would be helpful to be a real help in terms of some of the clients that end up going to the medical emergency rooms. The second big bridge of what's been coming out and this has been in the works for a couple of years. There's a whole crisis system. It's not an ED. It's also a whole crisis stabilization centers. Going to have twelve across the state. Two are up now. We're getting some others certified soon. Police can bring them to those. EMS can bring to the stabilization centers. People can walk into the stabilization centers. They serve adults. They serve kids. 24 hours. They will have a team. They will connect people to other needs. There are crisis residencies that we've been putting up across the state linked to the crisis stabilization center. A lot of that is still a work in progress, but it will build a system where urgent care can be brought to somewhere other than the emergency room. That's a big, big lift. Also our mobile crisis teams will be expanding. There's a number of pieces to the puzzle that we're missing. The way I like to put it is when someone was in an emergency room, we had no safe place for them to put their head and to make sure they got treatment the very next day. We didn't have it in the system. That causes an inevitable problem. To the he extent that we can put that in place, that people have a safe place to be. Someone

that they are met, let's say, in the emergency room or at least... Maybe they met them visually. Maybe they talked on one of these things. They called them on the phone. That person can connect with them. That I think can get people out of the ED. One of the biggest problems I know are these dually diagnosed. I know it's connected to individuals who have both mental health and developmental disabilities. That's why a big chunk of what we're doing is going to be working on the kinds of transitional residence, beds, whatever will work for that population in terms of being able to have them leave the emergency room. Not a good place for them to be under any circumstances where they may have to wait for some placement in the system that's appropriate for them. That's just a bit of a snapshot. What we are also pushing for something you had mentioned, Dr. Heslin. All these crisis services will be paid for through insurance, both commercial and medical. Some of them will be paid for by 2024. Most of them will be paid for by 2025. That's the big push, because I think the lack of commercial supplement in behavioral health is a huge financial issue. We also got in this budget dollars that commercial has to pay school based services, as well as medical expenses for basic services. We have an increased rate. Commercial has to pay the rate. I think that's the first time that we've pushed something like this that has said basically you can't underpay for mental health. Everybody's got to pay. It's got to come from both the commercial side and the Medicaid side. That would be the school based services for kids. I know on the other end of the spectrum, but it's the beginning of a model as to how when you say these services aren't financially viable it's partly because...There's nothing else. Very few other things in our health care system where Medcaid pays better than commercial. Behavioral health, oddly is one. That's fascinating. I think when you put that into the context of whether or not a service is financially viable becomes very interesting as to how they're going to nip and crush it over decades for individuals with mental illness that started way back with the beginning of Medicare, Medicaid, where state hospitals are supposed to pick up the tab. It's a fascinating cultural thing, but it's something just to keep in mind. We're doing all of these things to bolster the system from various ways. One brief for us about workforce. It's the most difficult I have ever seen. We used to have a crisis with docs or crisis with social workers. Now, we have a crisis with everybody. It's very, very difficult. We can get a 4% COLA, which will help our community based services, which are important to hospitals because you have to discharge to them. Another important piece, which is in the budget is an expansion of the behavioral health from thirteen to thirty-nine across the state serving an additional 200,000 people. Why is that good? Because the certified behavior centers have a much more cost base reimbursement system. We're expanding them on a basic model. They're also going to get payments. They should be able to grow. They should be much more financially viable. They are required to do outreach. They are required intensive services for individuals leaving hospitals. They are required to do integrated mental health services. I think that they offer a real ability to build on the community system, which ultimately is what's going to help save ERs is the stronger community system so people don't get to the point where they end up in the ED. another piece of this budget is building the community system. That's why I'm so excited about the budget, because it goes all the way from prevention to building the community system to trying to solve some of the issues in the hospital. It's a significant investment. The Governor always talks about it in terms of a continuum. Honestly, that's what it is. If you don't have a continuum in behavioral health, at each point you get blocked. It's like putting in your finger trying to just hold the water back. Now, the biggest problem we have is we don't have all the workforce yet to kind of come in to all the services that we have the money for. We are doing a lot of work on the pipeline for universities in terms of trying to give scholarships, incentives, offer individuals to work in the field. We have a loan forgiveness program for psychiatrists. We got $5 Million in this budget for the loan forgiveness program, the social workers and psychologists and mental health. If we can get those individuals to loan

forgiveness they then work for years with you for the price of the loan. Again, there are various incentives we're trying to do across to grow the work force, but I don't think that's going to be easy for a while. I think it's going to be difficult. There's been a migration to telehealth. Telehealth is great. We have to have telehealth, but it has been offered for some people to move into a more private sector with telehealth, which is financially very lucrative. I think at this point in time we're dealing with those stresses, but I think the pipeline is critical and we would love to work with any of you who want to have internships or special reach outs for people to work in your field. We've always found that we can do some education. People work in the field. They'll come. They may not stay forever with you institution, but they come or they stay for a while because people do want to do the work. We would be glad to work with you on that.

Dr. Rugge Dr. Sullivan is quite the review of the landscape.

Dr. Rugge Few raised hands here.

Dr. Rugge Dr. Soffel.

Dr. Soffel I wanted to come back to your comments about the new crisis intervention and crisis stabilization services, which I think are really essential and important. I'm thinking about health homes and all of the investment that New York has made in health homes over the last five to ten years. I'm curious about how this new crisis intervention overlay will interface with health homes, what we've learned from health homes about what works and what doesn't work, why perhaps health homes were not as effective as we had hoped they were going to be. How this is different from and better than in some sense what we have invested a lot of time, a lot of money and a lot of energy in building.

Dr. Sullivan I think there's a lot of ways that the health homes can definitely work with everything that I've said. Well, let me say, the teams are at a level above health home in terms of intensity. I think for our seriously mentally ill we need that. Now, the health homes. We have something in the health homes with health home plus, which is for individuals with mental health problems. We've been pretty successful in pushing that out there and getting a number. It's a little less intense than the other teams, but we work with those teams. Sometimes individuals can go to those teams instead of the others. Basically, the stabilization centers will be contacting people who are connected to health homes to make sure that those health home coordinators know where they are, what crises they are in, how they can be helpful. Sometimes the health care system even though someone may have something, nobody knows about it. Psyches, which is a system that we have in mental health. I mean, that alerts people to whether you're in a health home, whether you're you have a team, this kind of stuff. We have a fair amount of them. We'll also be checking on that. The stabilization centers will have the time to connect the person to whoever they are connected to. Sometimes you have the call. You know this person is involved in your health home. They never contact. We're going to connect you. They're going to be doing a lot of that. They're going to be working within everything that's out there in the system to help connect people to what they need. I think that that's where it sometimes that's difficult. Is not easy to just sometimes know which health home you even belong to. They can find it out. They can work with you to get that connection. I think we're going to be working very closely, basically with the Health Home Program and with all the other services that we have here. Everyone's talking about the social determinants. We have a wealth of social service agencies across the state. I think that's something that these teams will be doing and the stabilization centers will be doing. They really do need to work within. Should become a place the community trusts and goes to. They are also

going to be incredibly peer oriented, going to have peers, family advocates, child advocates in all the stabilization centers.

Dr. Rugge Dr. Lim.

Dr. Lim Thank you.

Dr. Lim I guess I have just some comments and one or two questions. I just want to acknowledge Dr. Sullivan and Dr. Smith and everyone at OMH. They have been working on building this continuum for years. I remember before the pandemic. I think it might be helpful if I share a little bit of our experiences at Sinai, because we built out a continuum of care, largely based on what they put into the OMH system way before the pandemic. Like, for example, Dr. Smith led this whole focus on sort of redesigning behavioral health crisis services, which is how we got to things like crisis stabilization, new mobile crisis teams. I can talk a little bit about our experience there. I think, number one, Dr. Sullivan was talking about I am a huge proponent. We have eight hospitals and basically three of them have it. We have one ED which is essentially like it. I think it's really important to recognize what exactly it is. It isn't just the psychiatric ED component. There is up to 72 hour observation beds like in medicine. There are these mobile crisis teams. There is a lot of different things that can be done with this triad of services. Interestingly for us, and I check in regularly with our folks, and this is both on the adult and kids side. It's not that we never have people boarding with behavioral health conditions. It's not that we don't have delays. We don't at Sinai in the services where we have the it in the hospitals. We don't have this big problem. It's not just that because we've got psych beds. We've got psych beds. We've got full array of services. There are all these requirements If you have a one if you come into the ED you have to connect them and give them an appointment within five days of being seen at a clinic, etc. or another service. That continuum, I think, is really important. I think because of the continuum that was already being built by Dr. Sullivan and her colleagues, we had also put in sort of key outpatient services, intensive outpatient services like day hospitals and hospital intensive outpatient along with clinics and a host of other services. We have services that I know a lot of other hospitals don't have, but we basically try to create a continuum of care, which is what Dr. Sullivan has been talking about. I think that's really critical. I think Dr. Sofeel had mentioned at a meeting before when someone was expanding a general ED. You had asked about have you worked with primary care partners? I think it's the same principle here. I think to address the ED boarding issues or the delays... It's not just looking at the crisis services or just the beds, but really what is that continuum of care. I think OMH has been really working very, very hard to build that out and fill in the gaps. I think the more people, the more I will say, the more we can have more that would be great. I think hospitals find a daunting because of the regulatory requirements. I think also there's this concern that then there'll be this influx, quite frankly, of people with behavioral health conditions. The fact of the matter is we have so many people now struggling with all kinds of issues. I think that triad of services is really critical. I guess my one question that I would have for the Commissioner is, I think to address some of the sort of provider hesitancy. Has there been any consideration or the ability to just sort of create like to divide up the components or to create like lite or something like that? Because the reimbursement rates from last year's budget are really great. They're really good

Dr. Sullivan Thank you.

Dr. Lim I mean, if there is some way to incentivize hospitals if it's not the full triad, I think that's where you get the best bang for your buck. Even if it's just parts of it, I wonder if that

might help ease some of the congestion, at least there as well as sort of have a downstream effect into the rest of the community and outpatient continuum.

Dr. Sullivan We're looking at that, especially in some of the smaller hospitals in the more rural areas where it really might not make sense to have all the components in the same way and might not be financially useful for them either. We're looking at that for sure. We have already done some satellite at places where we've been able to. I think yes. One of the things that we're looking at is how to be more flexible. We have to be careful because Medicaid rates you have to watch out. I think, yes, we can. I think you're right. I think it was really designed to be a kind of a big urban center. It doesn't always make sense everywhere. We're trying to do it in a way that's more flexible as we roll out. We're looking for ideas. We'll see what we can do to modify it. It's a great point.

Dr. Lim Maybe sort of a parking lot kind of thing is I do very grateful for OMH to be here, but I think when we're talking about people with behavioral health conditions, there are also people in the ED whose primary diagnoses is in SUD and is for acute intoxication. I think that's also if anything, I think we struggle more right now with sort of the larger and larger volumes of people with a primary SUD diagnosis who are seen sort of in the Oasis system not put Oasis on the spot, but I think if we're talking about behavioral health it's not just about people with psychiatric conditions. It's really the whole gamut. There's different strategies and different things that we can do I think for people with primary SUD diagnosis.

Dr. Rugge Thank you very much.

Dr. Rugge Dr. Heslin.

Dr. Heslin Thank you.

Dr. Heslin As you keep talking, Dr. Sullivan, you peak so much interest in lots of different things. I wanted to just ask a question about the CCBHCs. You mentioned that they were doing integrated mental health and substance abuse or use. They also have a medical component as well. Isn't that correct? They can do all services on the same day as opposed to having to divide things up? I think that's how CCBHCs work. I just want to see if the newer version has that as well.

Dr. Sullivan Many of them do, some of them do, some of them have connections to primary care. One of the things we've struggled with is the fiscal viability of primary care in mental health clinics. Trying to figure out a way to make that more robust. They have to have a very tight connection, but they are not required to have a wide array of services on site. I think if we could work better with some of the kinds of regulations and issues we would love to have more of them on site. I think that that kind of integration is so so critical and is one of those areas that working together with DOH, I think we could do a lot of good work on seeing if we could make that financially easier to have medical people actually on site for our clients. That would be terrific.

Dr. Heslin 100% agree. I think that is something that we should definitely take back as an issue.

Dr. Heslin The other thing is, as you talked about the challenges with the different patients that are showing up in the emergency room between the DD patients and the substance use patients. There's also the third category, which is becoming, I think, even larger, which

is the psychiatric medical patient, which is where they really can't be necessarily on a medical unit because of their psychiatric issues. You got the opposite end sometimes where they can't be on a medical unit because of their psychiatric issues. One of the categories we might want to think about is literally some sort of psychiatric medical bed. We have med surge beds. We have substance use beds. We have a bunch of different things. Maybe we need to actually start thinking about that we take care of the whole patient. We find a place that's appropriate and actually maybe think about making a whole new category, because I think we're going to see those increasingly complex patients that we really don't address necessarily in locked units on one side that we really don't address in open units on the other side. Just as a thought.

Dr. Sullivan I think it's a very important issue. There are what we call med psych beds on the psych licensing side. They tend to be limited in what they can provide in terms of medical support because of some of the requirements of ligatures and all kinds of things that happen. I think similar, but it's somewhat limited. What some hospitals are beginning to do is to cohort some of the clients on the med surge side. They need increased staffing and increased ability to work with those clients. I think that's something we should look at. I think if you were to do something like that, then maybe even on the medical side, you should have a different rate. You should get some money for that. They may be more social workers. They may need some counselors. I think there is that subgroup. I don't know that you have the exact model yet to do this. We should talk about that and see what might be possible in terms of cohorting on the medical side in some way supports for some individuals. Also on the psych side, the psych licensing side. You're absolutely right.

Dr. Heslin Where the issue becomes, I think is, is that those are the people that stay in the emergency room. Since we're talking about ED boarding and that was kind of the original purpose of this discussion. They're the ones that tend to never get out of the emergency room because regardless of what bed availability is none of the beds are appropriate. It's starting to think through how we could get appropriate beds on the inpatient side. All the other things that you've outlined already. I think we should maybe have further discussion if you're willing to do that.

Dr. Sullivan That would be great. That would be great to talk about, because I think it's very important. I think that they're also some of the most costly, obviously, the combination psychiatric problem and the medical problems. They often don't get the kind of comprehensive care they need. Yes, let's talk about it.

Dr. Heslin Okay.

Dr. Rugge Moving along.

Dr. Rugge Harvey Lawrence, I see your hand. I don't see your face, but I see your hand.

Harvey Lawrence Dr. Sullivan, thank you so much.

Harvey Lawrence This feels like a graduate level lecture and I'm trying to follow along. As a FQHC and some places around the state FQHCs are probably maybe thirty or forty miles away from the nearest hospital. Even within the urban areas, sometimes some of our clients approach to the hospital is forty miles away because of the level of trust and relationship that we have. Much of this discussion has been focused on hospitals. I understand that there are certain levels of care that on a primary care side we're not able to provide. I do recall in your conversation, you mentioned that it's really important for the

entire care delivery system to work, because in our world prevention, an ounce of prevention is worth a pound of cure. To the extent that we are looking at patients that have behavioral health challenges, we do engage, do provide some level of services. In this design, what role, what additional role do you see for primary care providers or FQHCs around the state to play a greater role? I think in intervention or assessing and being sort of a gatekeeper? Because it seems like the scale of the problem is so large. We're talking about beds. I don't know if we'll ever have enough beds. What are some of the mitigation that we can do to maybe slow down the need or demand? At the same time maybe triage and provide people with opportunities that don't necessarily result in them having to be in hospital beds or boarded in the ER.

Dr. Sullivan So much can be done in primary care, especially with depression and anxiety disorders. It's often important to remember depression is the second largest disability worldwide. It is huge. It is a huge effect on society, on parents of kids, on people's ability to work on the burden for disability. It's huge. Primary care often was where people with depression and anxiety sort of come. They don't come to us. It's the assessment, but also the treatment can be very well done in primary care. We've done this the collaborative clinics across the state. I know the FQHCs I've worked with have done this too. You can do really great work. What's interesting is that also for the more seriously mentally ill who were pretty stable. Maybe then took some psychotropic meds, etc.. In other parts of the country where we don't have quite as robust a mental health system primary care does a lot of the work with those individuals too. I'm not trying to push that, but I'm what I'm getting at is I think the primary care can be a place to, first of all, be open to hearing what the problems are so that you can find new issues, especially for depression, anxiety disorders they trust their primary care doctor. The other thing you can do in primary care and we've done this with Project Teach, shortage of child psychiatrists. We fund a consultation service for any pediatrician who wants to call a child psychiatrist and get some assistance in working with a family. Call them. They can do video. They can do consultation. We also have some training, but they don't have to do that. That's free of charge. Across the board, anything you can call. Now, anyone can call about maternal health to the same number. They can call and talk with a psychiatrist who understands whether or not a mom, for example, could take antidepressants while she's pregnant so that we have a helpline for that. We would love to work with primary care to think about how to expand that to also primary care consultations for individuals. I think there's tremendous role the primary care can play in helping. We know that the anxiety disorders and the depression were doubled or tripled, both for adults and kids across the state. A lot of that could really assessed and then if possible, I think treated successfully in primary care.

Harvey Lawrence Just one follow up.

Harvey Lawrence There are health centers including ours soon to be that have urgent care centers. Is there some role there to help stand up these urgent care centers in this space so that they could serve as an intervention because many of them are operating after hours?

Dr. Sullivan I think it's a great idea. I think that we thought about this. We haven't gone too far with it. I think that's something that maybe could be suggested that there be more integrated care between health in those urgent care centers as those are coming up across the country. They're isolated off. It's not necessarily the best. Health and hospitals, I think, has done some work on doing urgent care centers or behavioral health as well. I think that, yes, we haven't done enough of that. I think that's a great idea because I think that would again, be an access point for people to get help. Certainly, what you call the

anxiety disorders. Those could easily be dealt with for someone in a crisis. They wouldn't need a referral anyplace else if we set up the system right.

Harvey Lawrence Thank you.

Dr. Rugge Thank you, Harvey.

Dr. Rugge Ann Monroe.

Ann Monroe Thank you, Dr..

Ann Monroe I'm just so happy to see both departments here today working on this issue. One of the things I would ask, and if it's not on the agenda today that we look at it in the very near future. What does the data tell us about this problem? We heard Dr. Lim say that where there are those she doesn't see as much backup. I don't know what much or it's a problem or this is bad. Those words don't help me as much as kind of a landscape of the data. Is it as serious a problem across the state? Is it a more serious problem, a dual diagnosis, whether that's SUD and mental health or developmental disability and mental health? What are the numbers? What is the data? I think between the two departments, you must have more than enough data to begin to help us get a handle on the picture of what this problem is that we're trying to solve. I know, at least for me and some of the others that I know on the call, having that as background from which to work would be extremely helpful in coming up with ideas to supplement what we're already hearing. I would put that request on the table if we're not going to be doing it today to really get a data picture of what and where and how is this problem. One last thing that I would suggest is that we add a health plan representative to this group. What commercial pays for and what it does, etc. I'm really glad they're going to be paying for a piece of what you talked about, Commissioner, but I think they need to be in on looking at the problem and helping to strategize or continue to have a bifurcation of commercial and Medicaid. I would encourage that sector to be added to the group.

Dr. Sullivan Very wise as usual, Ann.

Dr. Rugge Absolutely.

Dr. Heslin Dr. Heslin, back to you.

Dr. Heslin I was just going to comment that I think in the North Country citizens advocates have some behavioral health urgent care centers that are actually for specifically behavioral health that they run. I don't know if that's a model that could be looked at. Right now, a lot of our care centers don't accept insurance and certainly don't accept Medicaid. While some of the FQHCs are starting to stand them up, it is a challenge in the state. I think that having places that are uniquely skilled in behavioral health, whether it's depression or anxiety or more complicated issues, I think that they've figured out a model at least how to start doing that. I saw that when I was doing some of my North Country work a couple of years ago. That might be something that could be looked at.

Dr. Sullivan This concept of integrating it better into the medical centers, I don't mean routine, but the less severe mental health issues, I think we haven't done very well. I think citizens advocates has something like that. Because of the rates and how you pay. We have all these medical centers coming up. They don't ahve behavioral health in them. In

primary care, behavioral health has gotten much more involved. Interestingly not in the medical centers.

Dr. Heslin To that point, the medical centers most of them don't accept Medicaid.

Dr. Sullivan Exactly.

Dr. Heslin They are limited in who. Their model is based upon a cash on the barrelhead model, which doesn't lend itself to either population, unfortunately.

Dr. Rugge I would only chime in to say, unfortunately, we don't really have a well-defined definition of urgent care or a set of expectations. That would be something that could be useful. We've seen from this discussion how important that service is, but we don't have a very good definition regulation what urgency means.

Dr. Sullivan It's faster.

Dr. Rugge Moving along, I see Ted Strange's got his hand up.

Dr. Rugge Dr. Strange.

Ted Strange Hi. How are you doing everybody? I think the discussion has been wonderful. Again, having all the parties on the table has been great. The biggest issue, though, still at the end of the day is workforce, which was described at the beginning of this and as the Chair of Medicine and working closely in terms of help trying to get physician recruitment in our area, both here in Staten Island and in Brooklyn. What we're seeing in New York State is the outmigration of young doctors leaving the state, both in terms of payments as they start their careers and tort reform, which is a big issue, which I know is a hot political button and needs to be talked about. At the end of the day, we can put all of these ideas on the table about access points and places that may or may not accept different insurances, but we have a workforce issue of retaining practitioners in this state right now of young trained doctors who may or may not want to do this. Of young trained doctors that want to go into primary care in general. When they do, they are leaving the state. I can tell you every year and in the last few days I've spoken to some of our young doctors who are graduating and are thinking of going to Florida and Texas and North Carolina, just to name a few states. I had a doctor go up to New Hampshire last year. Again, not just for lifestyle, but for, again, reimbursement. They're paying off their student loans that they're coming out with huge student loans and tort reform. Big issue on the table. When you're starting to deal with these multifactorial patients that deal with behavioral health and medical issues, are you dealing with a very difficult group or a difficult area that delves into multiple areas? If they don't feel they're getting the support and the backup that's necessary. Again, we need to talk about this. Because at the end of the day it's going to be about workforce. We can talk about centers and that's great and that's a good stop fix piece. That doesn't give you what Mr. Lawrence talked about, which is the wellness care and the preventative care. They're not going to provide that preventative care. It's a Band-Aid. It may be a Band-Aid over a gaping hole that really needs staples and sutures, if I can put it in medical terms. I think we got to get to figuring out the workforce issue in this conversation.

Dr. Rugge I hear no rebuttals.

Harvey Lawrence I think it's spot on. It is the issue and I know I'm not next, but I think there was a recent article in The New York Times which equated in terms of quality of life, $100,000 earned in New York City is equivalent of about $33,000. I know that's just the city and then the quality of life. Dr. Strange is really spot on. We've had primary care clinicians say, I've had it. This is not what I signed up for. This is after at least two decades of being in primary care. I think the quality of life issues. I think we have sort of left that out. Many clinicians feel that they are pretty much painting by numbers based on the metrics that we are asking them to provide and to look at and monitor. We need to I think also, in least from what I hear, is to really look at how medicine is being practiced and what we're asking our clinicians to do in addition to looking at the compensation issue. That is just to retain the ones that are here. Whatever else we need to do to recruit is a totally different kind of, I guess, an issue.

Ted Strange You hit spot on, Mr. Lawrence, because we're asking our young primary docs to now become psychiatrists in some ways. There's certain things that we can do. We took GYN out of some of our primary docs offices because we said that wasn't the standard of care in terms of in urban areas they should be seeing gynecologists and not primary care doctors to do certain HYN. You can argue that back and forth because family practitioners probably do a good enough job in some of the basic stuff. Again, to your point, we are pushing our primary docs to do things that push the envelope on certain things without liability reform on the back end of that. I don't want to put liability reform being the biggest issue because I think we all should be practicing to a standard of care. When we can't we shouldn't be doing it. It is an issue. This issue is being taken up in other states. We are pushing the envelope here. I can just tell you in our local practice, we've embedded some social workers in some of our local practices to help our primary docs with those psych issues and try to get to a psychiatrist when we can when it really becomes an issue. That may be some of the ways to help this. Again, some of our primary docs will only prescribe to a certain level of an antidepressant. The next level you need a more professional or a more skilled person to do that.

Dr. Sullivan I really think some teleconsultation connections. There are health professionals, especially in practices. I think looking into that for the opportunities and for them to even treat, prescribe, work with individuals in primary care practices might be helpful. Some places have done that and that's expanded their access.

Harvey Lawrence Dr. Sullivan, that's a great point. One of the issues that we have as a community health centers is that, in fact, we get penalized for providing telehealth at this point, if neither the clinician or the patient is in the practice, which I don't know how that yet in other articles that's permissible if they both could be out of the practice. Given the incredible need for behavioral health services, you would think that there wouldn't be a penalty in this situation, but that does exist. Some point, the system is a little disconnected from the reality and disconnected from the need to have these little plugs of these little differences that can make not a monumental difference, but could be impactful in neighborhoods and then ultimately, I guess, be impactful.

Dr. Sullivan I think it is important and I think it's something that this group could bring forward. Basically, Article 31 clinics, you do not have to be on site. We knew that that would be an issue for behavioral health and some of the federal regulations that are coming down. Again, there are all kinds of exceptions. Might be something really worth looking at again, in New York State for DOH for behavioral health. You might want to keep it for medical. You want someone on site. It is something that could be looked at seriously because it affects the hospital based clinics as well as FQHCs.

Dr. Rugge Dr. Morley, you've been very patient.

Dr. Morley Thank you very much, Dr. Rugge.

Dr. Morley I just wanted to go back to Dr.'s points about the data, which is always a key point and a particularly important issue for us. I did notice that when she mentioned the issue of data, yes, we are drowning in data, but I also saw the hospital and hospital association folks, the antennas went up, the ears went up. I think the hair on the back of their neck would have. They have been providing us with lots of data. Is it the right data for these questions? I don't think we're quite there yet. DOH and OMH have had several meetings and going to continue to meet to talk more about what is the right data and to work with the associations to get the right data to answer these questions. Our issue here that we're talking about today, but there are other questions that OMH had to answer relative to the funding and to the Governor's Office. This is a key, key concern for us. We will be working with them to get the optimum data that we can to answer these questions.

Dr. Sullivan I think that's so important, Dr..

Dr. Sullivan Thank you for saying.

Dr. Sullivan It's hard. EDs are so busy. Everybody's so busy. Quite frankly, we don't have good data on how many people, for example, are waiting for a bed. We don't have good data on that. We don't have good data on how many people wait more than 24 hours in emergency rooms for services. We do know how many people get admitted. We do know occupancy from admissions. We know all those things. Getting the data on these other things is not easy. It really needs some kind of system in the emergency rooms to get that data better. Work with everybody to try to put it together. We're not even going to know if we're helping the problem. A lot of what we have is reports and every now and then we've done date and time surveys to know. We don't have the ongoing capacity yet for a lot of what would make sense. We do have lots of other kinds of data. You almost need to know how many people are in my emergency room waiting for bed? Does my emergency room have this every day? Does my emergency room just have this once in a while?

Dr. Rugge Just as an editorial comment for the first time because of this meeting and the attachment attached to it. Consolidated Crisis Response System Report. Was really taken by that initial division of making sure we have someone to call, someone to come, somewhere to go. I'm just suggesting, may be a helpful framework for us as a committee and then a council and then as government to say behavioral health effects affects all of us. It is everywhere. We have to make sure we're getting the most appropriate care at the appropriate level every time. Again, just trying to struggle with all this information, all this commentary. How do we divide it up so that we can have a series of recommendations that will be telling and effective and meaningful? You've helped to provide that, I think.

Dr. Sullivan All the crisis working to it is very, very important because I do think that the 988 line, when you talk about EMS and even EMS waiting and who EMS is bringing to emergency rooms. If we can get 988 right and if we can begin to get calls going to. We have a big mobile crisis system. It's not immediate. It's not like we can get out there in two minutes. A lot of calls to EMS don't really require sometimes that immediate response. If someone to talk to the person, understand what the issue is, set up somebody in a couple of hours. Maybe not immediately. I think we need to get that down. That would again, decrease the pressure on emergency rooms and on people who come. I think the all we've

been talking about also connects in to what that system is in terms of emergency rooms, especially in terms of EMS capacity and what that means. I think we need to do that kind of integration so that we can move crisis calls as much as possible to the mental health system rather than to the medical system.

Dr. Rugge Although primary care is part of the mental health system.

Dr. Sullivan I'm talking about somebody who is calling for a abundances. That's what I'm talking about. I think the question here is you could combine mental health with EMS. Very interesting models out there that combine the two things together. You want to put the emphasis, I think, back from some individuals who end up being picked up by EMS and then going to an emergency room could possibly go to the stabilization crisis center or maybe could go over the crisis team. They may not need to go to the medical emergency room.

Dr. Rugge Absolutely.

Maclain Berhaupt Thanks, Dr. Rugge.

Maclain Berhaupt I mean, to your point, I think you really outlined it really well about sort of what a coordinated system could look like and the three aspects of trying to connect all of these complex systems together. One thing I was wondering, Dr. Sullivan, if you might be under consideration is it's so exciting to see such a huge investment coming out of the budget around behavioral health and all of these programs that you outlined, the transitional beds, the support of housing, the critical time intervention teams, the crisis system, the crisis stabilization centers. I'm just wondering if there might be consideration given to... I imagine your team is hard at work. I was trying to figure out how these programs are going to get put out on the street in the RFPs and how all of this is going to work. If there be any consideration given to target maybe a subset portion of all of these programs to target this specific population that we're trying to address, which is, you know, folks that are sort of stuck in the ERs and they shouldn't be there in the first place. We don't have the right systems in place to get the social workers in there. We're having trouble getting them out into a place that serves their needs in the best possible way permanently. I'm just wondering if there's a way to look at all of these programs and think about like a small subset across these programs that would really be targeting the same thing and the same population.

Dr. Sullivan Actually, a big chunk of the services are going to be serving that. When we talk about critical time intervention, those are focused on individuals of very high need. Individuals who have been hospitalized, gone to emergency rooms, had multiple emergency room visits, left the emergency room without the appropriate level of care or are referred from our clinic system because we know that they're in dire need. Those are really pushing towards the very high end, most challenging, most complex cases. Now, some of the special training. For example, if you have a dual diagnosis of disability and mental health and you're in that high end you're going to need special training. Involved in the criminal justice system we now have teams. We probably will have some criminal justice focused CTI teams to work. Because they're special needs. Individuals have managed to get caught into the criminal justice. A lot of these services are for the high end. The beauty of the whole thing is that there's also support for the clinics and the other individuals who might come in. $20 Million to expand basic clinic services. Money for school based services, big time and money for primary care clinics in primary care clinicians offices. That was significant. We want to cover 300,000 families by five years

from now. All the budget goes to prevention through what's called middle level care all the way to the high end. There's a lot of investment in the high end. The housing is for the high end and the housing and all the intensive services and then specialized groups within that. That's where some of the money has in my book in terms of services not been invested over the years in the way it should have been. We're finally doing it now for those individuals who have the most challenging mental illness.

Dr. Rugge Ann Monroe, I see your hand is up.

Ann Monroe Dr. Soffel was before me.

Dr. Rugge Oh, I'm sorry.

Dr. Soffel Thank you, Ann. I appreciate it.

Dr. Soffel I want to make an observation that may be impolitic, but I'm known for that. I'm thinking about Mayor Adams and the new policy that is, in some sense disease defying, if that's a word. Homelessness, by saying anybody who is homeless is by definition mentally ill, because if they weren't mentally ill, they wouldn't be homeless and therefore can be picked up against their will and brought in for both evaluation and potentially institutionalization for a period of time while they are evaluated. I'm listening to what Dr. Sullivan is talking about and this crisis intervention and the need for levels of appropriate intervention and well-trained staff to do assessments and evaluations and it feels very disconcerting to be watching what's happening here in New York City while the state is developing this much more nuanced approach to how we deal with what I will acknowledge, living in New York City is certainly a much more visible presence of people with serious mental illness on our streets. I don't know that I have a question, but I'm sort of interested in how the Office of Mental Health observes and supports what the Mayor is doing here in New York City.

Dr. Sullivan Two things. First of all, I think that you're absolutely right in terms of the importance. Let me just give one example.

Dr. Soffel You have to be politic. I do not. I appreciate that. I really do.

Dr. Sullivan First of all, in terms of the city, we're working very closely with the city. I think that on the ground with the teams that are part of our residents committee, the teams that are working with the homeless on the ground, they've always had the philosophy you have. They're the core of what's happening in the city. Now, I know that there's a certain amount of talk about people being brought involuntarily. I can tell you that at least we don't have the data from the city. Our SOS Teams, Safe Option Support Teams engaged about 700 people on the subways that they're working with. We brought about 300 people to the hospital. They all came with us voluntarily. Half for medical reasons. Half because they needed some psychiatric help. They came with us. They key here is engaging people. Now, once in a while, maybe somebody has to be brought involuntarily. I think the more the teams work to engage people and work with them and respect them, I think that goes a long way. It takes time. It takes time. We safety housed 300 people and we've got 60 into permanent. It's moving. It happens. It works. We learn from them how to engage. Truly, I think we are learning a lot. We have a unit where individuals who have been on the street for a long time. They had an assessment sheet. The first topic that they put on their sheet was aspirations. In other words, saying someone who has been homeless for five years, ten years. They have aspirations too. I think that that's where we have to begin to think.

That's what engagement is. It's not just we have a room and board for you. That's not it. You have to connect people where they are and what they want for themselves and for their lives. You have to be able to have them trust us when they failed to trust us for a long time. I think that that's the work. It takes time to do that. When you do that for a certain group of individuals who've been on the street for a long time. I think I think we're getting there, though, and we're learning. We're learning how to engage people. That's happening on the city side too. Even though I know what's said publicly, I think there really is an attempt here to really work and help people get what they need.

Dr. Rugge Ann, I think it is now your turn.

Ann Monroe I appreciate the looking for new models. I think it's important. I also think that we at PHHPC need to look at barriers to current models being more effective. You may remember that a long time ago now Dr. Rugge and I chaired a group with Jennifer with the staff to look at a limited integrated license that would allow behavioral health, Article 31 and Article 28 to be on the premises at the same time. It is counterintuitive that you can't have the staff on site at the same time. We worked very hard on that. It never came to be. When I listen to Harvey Lawrence talk about and I'm not sure I got it right, but if you have a provider who's not in the network and a patient and stop the network or whatever, they don't get paid, whereas at OMH they will get paid. I think that in addition to new models, which will take time to integrate into the system, we have an obligation to look at ways that we can smooth the work for both departments. We're not creating our own barriers to actual integration and effective action. For me, as a member of PHHPC, it's equally important to develop new models as it is to remove the barriers from current operations that limit our ability to work together. I don't want that lost in the excitement of looking at new models. I just make a note for myself through PHHPC to make sure that we address that as well.

Ann Sullivan You're absolutely right.

Dr. Rugge Nice point.

Dr. Rugge Sarah DuVall.

Sarah DuVall Hi. You all saw the report that we shared and then Dr. had mentioned that there so much more to do. We recognized that. I did have a question about some of the data and the work to figure out what the capacity needs are. I think our report did a really great job in identifying the populations that were really struggling, their characteristics, many of which had IDD and mental illness and then also some of the reasons for delays, so going into some of the payment issues and then just the plain lack of options and then reasons they were being declined for services. Mental illness was high on that list of reasons for declination. All of those need to be looked into a little bit more in detail. We didn't include much about where they should be placed because there seems to be so many questions around appropriate placement and who would qualify for that placement. What I'm curious about, and I think in conversations that we've had with members we've struggled with and wrestled with, is what is the best way to identify the capacity that's needed? What's being done across the state and in hospitals are a great setting for these issues. By focusing on them, unfortunately, and then in the data collection, they get so much of the attention that is desperately needed in the outpatient settings. I mean, hospitals are being used as a placement of last resort. When people throw their hands up and they can't find services in the community, they're going to the hospital. They end up stuck because they can't get into those places. That's what we ran into. I guess my

question is going into when looking at capacity, what can be done? Is it possible to start looking at some of those community settings and the waitlists and some of the barriers there? We also found eligibility process for services and referral processes being contributors of delay, particularly in the emergency department.

Dr. Sullivan In some areas we have very good data. For example, for our RTFs and our CRs and certain things. We have good data on waiting lists and who's waiting. The clinic system, it's a variable. We do have some data on it. Again, it's a reporting and a burden kind of thing. We have reports. Right now since the pandemic, the waitlists by and large, doubled or tripled. We have large numbers of people waiting. You're absolutely right that if you're going to really do it right you start with prevention, you do the infrastructure and then you decrease the individuals who need that high end service, whether it's an inpatient or something else. Building all that and the access to all that. Accessibility to those services is limited right now by both workforce and finance. I think that those are the things that we're working on. The access is definitely not there. All these new investments, I think will significantly improve that access problem, but it probably won't solve it all, but it should significantly improve the access problem. You're dealing with a mental health system and a system that had been underfunded for decades, decades upon decades upon decades. It's not easy to just jump. I think all the dollars... This billion dollars would jump start in a major way. I think that certain models like we've been working with. Because they've been able to recruit staff because of the financial system. Partly it's because they provide a kind of comprehensive service and people like working there. It's a combination of things. Before the pandemic, almost none all of ours didn't have waitlists. Some of them do. I think that, again, there's been an increase. It's not just that we're getting back to the pre-pandemic. There's been an increased push for need at just about every level across the mental health system. They were doing very well prior. We're trying to get them back and be able to do that. There are some places that don't. We're looking at that to understand why. Sometimes it's just geography, but sometimes it's not. Sometimes it's practice, what's in the community, how well people work together in their community.

Dr. Rugge Alison Burke.

Alison Burke Hi, everyone. This is really refreshing and great. I know I speak for all of our members, what an unprecedented opportunity this investment presents. I know Commissioner Sullivan, we've had this conversation, and I think everybody on today's call recognizes the workforce challenges. Where I'm not clear is I think today's focus was on the pressure in the emergency department. I think we all need to recognize as Dr. Lim and others and Ann Monroe pointed out, what's working, what's not working. One thing that we're hearing from our members right now. It's across sectors. It's community based. It's hospital based. It's county based. A number of the high intensity programs and services in the community are having the same workforce challenge. They're not operating at 100% capacity. One would hope, given the unprecedented need, we might even be able to like, I don't know, increase caseload, relax some of the documentation or other things so that we're seeing more people. We're seeing more people before they get to the emergency room. A lot of the billion dollar and multiyear investment is on building new things. There's not been a lot of discussion yet about shoring up the existing programs and providers. The Field of Dreams takes a while to build. We're so grateful for it.

Ann Sullivan I do think, though... In the past year we've increased clinically by 10%. We significantly increased rates. The Medicaid rates over the past two years. They were started with the federal investment, but they've continued by the state. Even though we got a bump up when those moneys came from the feds, the rates aren't going back down.

There's been a significant investment. There's been $104 Million in housing, in paying for the support services and housing over the past two years. There's been a significant push into the infrastructure. We're putting up forty-two more. Those, you are absolutely right. You suggested we're going to be doing a new model. Something which lets them have a somewhat logically slowed to be able to see the absolute numbers which we were doing with fidelity of the best practice. Maybe that isn't needed anymore. You're absolutely right. Maybe some of these services are a little more flexible. Very important. The investment in the infrastructure has been significant. Even expanding these thirteen. Existing clinics under a new financial model that will support the infrastructure. There is a fair amount of infrastructure, a lot of infrastructure investment as well as new stuff. That's what I love about the program, I have to say. It's the continuum, but it also doesn't just say, we're going to do this stuff and not worry about the old stuff. It's embedded in many, many pieces, but there is a significant infrastructure investment as well. Even our loan forgiveness plans that are coming out, that's infrastructure. That's dollars that will be continued ongoing. So far it's been successful in getting people into our programs in the community. There is an investment in infrastructure that I think, again, is new. I mean, we haven't really in the past done it quite that well.

Dr. Rugge Harvey, I give you time for a valedictory comment and then I've got a few closing remarks.

Harvey Lawrence I guess it seems that, you know, either the architects, the engineers or the plumbers in all of this, the contractors. I think communities have been through a pretty traumatic past three or four years through the pandemic. I think people that were on edge are probably more on edge. Some people are suffering because they experienced the loss of friends, families that have had their lives turned upside down. I guess zooming out from a public... I guess public or population health perspective is what can we do to promote healing and wellness in just in a more general way to make people feel at least give an opportunity for people to be joyful and happy and well. Because we're focused on all of the nuts and bolts of how to care for those folks that are all on the other side. What do we do from a population perspective and make people feel a little better about having survived the pandemic and hopeful about the future? Because that sort of filters down into everyone's life and people that are already under stress and need to know that there's hope to really keep them from crossing over on the other side of the line. I don't know if this is the proper place, but I don't know if it's a Feel Good About Life Campaign or something that the state can undertake and can they spread across the state to sort of give hope and inspiration to people. As we are doing all of this sort of infrastructure work, but I just think that that's important because I don't know if people have had an opportunity to heal. I think people are emoting as a result of the stress that they've had over the past three years. We've got to just turn to switch. Let's move on now. The pandemic is over. I think for many people, they're still feeling some of that.

Dr. McDonald Harvey, I just want to jump in real quick here. Sorry, Dr. Rugge. I want to thank everybody for letting me just sit in and listen today to this meeting. Harvey, I think you bring up a lot of really good points. One of the things that's not lost on me is we've gone through this amazing population trauma. We're still going through this population trauma. It's very substantial, though. I think there's a lot of good content today. I wish I knew how to make everybody feel better. Quite frankly, I don't think mental health is that simple.I'm not suggesting you thought it was either, but it's like I heard a lot of really constructive things that are in the budget, a lot of constructive ideas. I do know our workforce issue in New York is substantia. It is a very significant issue here. It's not lost on me that that's not going to get better with us working independently with each other. That's

really figuring out how do we work with all the state agencies to see where we get with that. I think this has been a very constructive, well thought out meeting that has been put together. I can't thank everyone enough for just all the work that went into this meeting. The idea is very constructive. There's a lot of things I took notes on to follow up with my team. I'm going to run to another meeting, but I just want you to know that I was listening to your entire meeting and I really thought it was great. Thank you so much for doing it. I hope you guys have a good rest of your day.

Dr. Rugge Thank you.

Dr. Rugge Just by way of a couple closing comments, one of the things we decided we should do an evaluation to see if this kind of Zoom meeting is actually helpful or not. I don't think that's going to be a problem to come to a good conclusion about that. I want to thank everybody for their comments, their thoughts and their participation. At least another challenge, and that is we will be meeting as a committee on June 26th, Monday, June 26th, few days prior to our council meeting. We will be empowered to develop recommendations for consideration by the council as a whole. Thoughts of people have, specific suggestions or actions that you think as members of the council we should make. Please jot them down if you can, forward them along so that we can assimilate them and be ready for action, deliberative action at our committee meeting. In the meantime, I can only say that I feel sorry for Jackie Sheltry, because she is charged with developing a meeting summary. That will be a little tough, but I think again, helpful to us all to try to record and make understandable to all of us the concerns, the considerations and the recommendations that we have in mind saying this all the time when we've always been living through stress all through the years. There's never been a lack of stress. Never to the degree it is now. It translates certainly into financial stress. At the very time where we have a state government, we have a Governor who has, by all indications, made the decision we can't simply throw more money in problems in health care. That we're spending all we can afford in health care. Therefore, we need to rearrange. We need to reform. We need to simply not ask in a manner asking for higher reimbursement or for new programs. These all have to be contained in one global enterprise.

Dr. Rugge Any further comments?

Dr. Rugge Dr. Morley?

Dr. Rugge Dr. Heslin?

Dr. Morley Ann has something to say.

Ann Monroe Sorry.

Ann Monroe I was just going to say that I think in addition to recommendations, if as soon as possible after the meeting if you could get to Dr. and to me your ideas about more information you might need in order to make those recommendations. Because that's two months from now. We could do a lot through sharing data or ideas before that. I would encourage that to happen as much as possible to share your thoughts. I know Dr. Lim had to leave and she had some questions for follow up at the next meeting. If you have those questions or data needs or whatever, please get them to Dr. and to me and we will make sure that they get factored into the process.

Dr. Rugge Yes, we're not confined to the screen. A lot of work that goes in between meetings.

Dr. Rugge Dr. Sullivan.

Ann Sullivan We're here to answer anything. I mean, if you think about these, if you want more information from us or what's happening, we'll be glad to give anything to the committee that you need. Please, please let us know. We can also just outline everythin. We have tons of sheets of paper that describe everything I said. If you want to see that, but just let us know what you need. We'd be glad. We'd be glad to have any future discussions as well on some of the really great ideas.

Dr. Rugge Exactly.

Dr. Rugge Please don't make this a one time event. We really need you all along the way because mental health is everywhere. It is expensive. It is a high, high level need. We need to work together to find the right solutions and the right way to go forward.

Dr. Rugge With that, thank you, everyone.

Dr. Rugge We will conclude the meeting.

Dr. Rugge Because we're not a committee, we don't need a motion to adjourn. We'll just make motions by end of the session and be seeing one another in the future, I'm sure.

Dr. Rugge Thank you very much.