DEPARTMENT OF HEALTH CARE SERVICES
Behavioral Health Stakeholder Advisory Committee (BH-SAC)
July 16, 2020
1:30 p.m. – 4:30 p.m.

MEETING SUMMARY

Behavioral Health Stakeholder Advisory Members (BH-SAC) Attending (by webinar): Barbara Aday-Garcia, California Association of DUI Treatment Programs; Jei Africa, Marin County Health Services Agency; Sarah Arnquist, Beacon Health Options; Ken Berrick, Seneca Family of Agencies; Michelle Doty Cabrera, County Behavioral Health Directors Association of California; Carmela Coyle, California Hospital Association; Steve Fields, Progress Foundation; MJ Diaz, SEIU; Vitka Eisen, HealthRIGHT 360; Sarah-Michael Gaston, Youth Forward; Sara Gavin, CommuniCare Health Centers; Britta Guerrero, Sacramento Native American Health Center; Veronica Kelley, San Bernardino County; Linnea Koopmans, Local Health Plans of California; Kim Lewis, National Health Law Program; Farrah McDaid Ting, California State Association of Counties; Frank Mecca, County Welfare Directors Association of California; Maggie Merritt, Steinberg Institute; Aimee Moulin, UC Davis/ Co-Director, California Bridge Program; Deborah Pitts, University of Southern California Chan Division of Occupational Science and Occupational Therapy; Jonathan Porteus, WellSpace Health; Hector Ramirez, Consumer Los Angeles County; Sarah Rock, Rock Health; Kiran Savage-Sangwan, CA Pan-Ethnic Health Network; Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Centers; Chris Stoner-Mertz, California Alliance of Child and Family Services; Jonathan Sherin, Department of Mental Health, County of Los Angeles; Catherine Teare, California Health Care Foundation; Gary Tsai, MD, Los Angeles County; Rosemary Veniegas, California Community Foundation; Bill Walker, MD, Contra Costa Health Services; Jevon Wilkes, California Coalition for Youth.

BH SAC Members Not Attending: Catherine Blakemore, Disability Rights CA; Jessica Cruz, NAMI; Alex Dodd, Aegis Treatment Centers; Robert McCarron, California Psychiatric Association; Mandy Taylor, California LGBTQ Health and Human Services Network, a program of Health Access Foundation; Stephanie Welch, Department of Corrections and Rehabilitation.

DHCS Attending: Will Lightbourne, Jacey Cooper, Kelly Pfeifer, Jim Kooler, Rene Mollow, Lindy Harrington, Adam Weintraub, Norman Williams, Morgan Clair.

Public Attending (by phone): There were 201 members of the public attending by phone.

Welcome, Introductions, and Opening Comments
Will Lightbourne, DHCS Director

Director Lightbourne welcomed everyone and introduced himself as the new Director of DHCS. As many know, I am not new to the state or public service and have served as

CA Department of Social Services (CDSS) Director in the Brown administration and in several counties prior to that. It is an honor and privilege to join the Newsom administration and the fabulous talented team here at DHCS. The challenges confronting us in these next months and years include immediate services and programs, in context of the COVID pandemic and also trying looking beyond the emergency to what has been a long-term problem of growing income and social inequities in our state and country. Underneath both of these, a continuing pandemic of racism that has made possible some of those economic and health inequities made so visible by the COVID pandemic. Today we start with the immediate agenda, but as we move forward, we will be taking up a broader range of issues.

State Budget Update
Will Lightbourne and Jacey Cooper, DHCS

Will Lightbourne introduced the state budget discussion. The May Revision proposal was significantly different than the January proposal yet necessary as a starting place given the extraordinary deficit. The subsequent collaboration and negotiation led to a fairly good outcome, maintaining status quo for most DHCS and human service programs.

Jacey Cooper offered a review of the state budget. The January Governor's budget included a large number of proposals; however, with the public health emergency and the budget deficit in the interim, DHCS in May proposed reductions. Through negotiations and discussions with the administration and Legislature, a majority of those proposals were rejected and/or funded in the final budget. DHCS will continue to implement the COVID-19 responses funded in the budget. We also will implement the skilled nursing facility (SNF) payment reform that was approved in the budget as well as eligibility changes. For example, the Aged, Blind, Disabled Federal Poverty Level increase will move forward. DHCS is working with CDSS and California Welfare Directors Association (CWDA) and others to determine the timeline for the implementation of those eligibility groups. The original date of August 1 implementation is not feasible; however, this is a priority and we will get this up and running as soon as we can. We are also working with the California Primary Care Association (CPCA) and California Association of Public Hospitals (CAPH) and other partners on the 340B Supplemental Payment Pool methodology. We will provide updates on State-only Claiming Adjustments. The hearing aid proposal remains in the budget with different start dates. You will see information coming from DHCS in the next few weeks to make everyone aware of timing.

In response to questions we have received, I would add that the DHCS budget is not a part of some of the budget triggers that other departments are subject to. The January governor's budget originally proposed the Behavioral Health Quality Improvement Project (QIP) and that was not in the final budget. However, the Behavioral Health Integration Projects will move forward. We have received hundreds of applications and are turning to that work. We will let you know the dates and rollout of the projects funded through Proposition 56 funds as well.

Questions and Comments:

There were no questions or comments from members on the budget.

COVID -19 Update, Medi-Nurse

DHCS Staff

Slides available: https://www.dhcs.ca.gov/services/Documents/071620-BH-SAC-Webinar.pdf

As reported previously, DHCS put forward almost five dozen waiver flexibilities to (the Centers for Medicare & Medicaid Services) CMS. Most have been approved. The main outstanding item is the 1115 Disaster Waiver request. We are working actively with CMS on the approval and hope to have approval soon. We will keep you updated as there are items specific to the behavioral health delivery system included. The public health emergency continues. We have gotten a huge number of waivers approved and in place. DHCS continues to analyze our situation as the public health emergency evolves for changes and new flexibilities. We are evaluating the flexibilities we currently have that may need to extend beyond the public health emergency. DHCS is analyzing encounter data from our various colleagues to look at what happened in the early months of the public health emergency, such as utilization of services and disparities. We look forward to engaging with you in the future regarding that data.

Rene Mollow offered an update on telehealth and other flexibilities. California was ahead of the curve on telehealth because we previously had undertaken a comprehensive review of telehealth policies and a stakeholder process. We received over 500 comments during that process and finalized an updated policy in 2019. That work was the foundation of COVID flexibility. Previous policy was narrower and limited to specific diseases. The updated policy leaves it up to the clinicians and beneficiaries to determine how services are provided, in-person, virtual, store-and-forward. We view it from the perspective of the benefit: Does it meet the intent? Can the service be provided in a telehealth modality? The goal is to maintain the quality of the services and we recognize that there are different ways to deliver services and want providers to have that flexibility.

The telehealth policy in place today, outside of the public health emergency, is available to licensed practitioners, clinic providers such as Federally Qualified Health Centers (FQHCs), Rural Health Centers, and Tribal Clinics. Beneficiaries retain the choice of how the services are delivered to them and not every benefit lends itself to that modality. We allow for e-consult between licensed providers to do consultations (not available for clinic providers). Telehealth is available both in the managed care and Fee-For-Service (FFS) delivery system.

As part of flexibilities approved during the public health emergency, we can also reimburse for telephonic services as an alternative to a face-to-face visit. This was done in light of social distancing to slow the spread of COVID-19. The telephonic service has to meet the intent of the face-to-face and be clinically appropriate in terms of the modality that is being used. We reimburse at the same rate we would otherwise pay for a face-to-face visit. If it does not meet the criteria for a face-to-face visit, there is a lesser reimbursement rate available to clinic providers for telephonic visits according to CMS

policy. We also have flexibility for the beneficiary and their home to be the originating site for services. Clinic providers, under the flexibilities for the public health emergencies, can establish a patient via a telehealth modality. As Jacey mentioned, we are starting to look at the flexibilities we want to make permanent and what types of federal approvals we need for that. I will note that the previous changes to telehealth policy did not require federal approval. Clinic partners can also leverage the use of Associate Marriage and Family Therapists and Associate Clinical Social Workers as billable providers.

In terms of teledentistry, dental telehealth is a narrower set of services, but they do have the flexibility to bill. Dental providers and allied dental health professionals can render limited dental services either via live teledentistry or store-and-forward for specific codes. As of March, we also allow for a temporary exception for dental providers to do consultation services by telephone or video for a beneficiary calling with an oral health problem and they can be paid for an office visit and the transmission fee for this procedure code in lieu of an in-person visit.

Questions and Comments:

Catherine Teare, California Health Care Foundation: Data will be so important and helpful in figuring out what to keep and, in particular, potential disparities in access to telehealth during this period. When do you think you will release that information?

Jacey Cooper, DHCS: We don't have that yet. As you know, the data has a lag coming from managed care in particular. We are working with the plans to gather early data while we wait for complete encounter data. We want to see data as early as possible to identify trends and information, and to adapt if possible, to any disparities. For behavioral health, there are challenges in the way telehealth services are reported that may make it difficult. We are beginning the analytics now, but don't have a date for you.

Rosemary Veniegas, California Community Foundation: Is there flexibility regarding same-day billing for primary care, mental health or substance use needs that might be addressed during a telephone or other visits?

Rene Mollow, DHCS: No, there are no changes in the rules related to same-day billing.

Michelle Doty Cabrera, County Behavioral Health Directors Association of California: One distinction to note is that County Behavioral Health has always been able to bill for telehealth. The transition of services to telehealth was able to happen quickly. While it has not taken the place of all in-person services, there has been a significant ramp up in behavioral health telehealth. It would be useful to know the extent that physical health is providing telehealth versus in-person to assess going forward.

Jacey Cooper, DHCS: On the behavioral health side and overall, we have had an expansive telehealth policy, both in managed care and certain parts of behavioral health, for some time. The big change with emergency flexibility, including behavioral health, is the telephonic services and the payment parity across all. We had a broad expansion of the telephonic services and we will be doing analysis of this. One of the core pieces that we are looking at is the value of face-to-face versus telehealth, as well as telehealth

versus telephonic services. How do we ensure the same quality outcomes for those visits? And it is going to vary across the delivery system. In response to COVID, we allowed telehealth services for almost all services. We even expanded it to physical therapy services. There are services where it is not appropriate. We will be evaluating across all services. It will be interesting to hear the behavioral health provider perspective about when things need to be in-person. We have seen reduced no show rates, but we need to evaluate what should move forward. We are looking forward to engaging with all of our behavioral health, managed care plan, and dental colleagues in conversations about the telehealth policy moving forward.

Hector Ramirez, Consumer Los Angeles County: I appreciate the presentation. Is there a consideration about the instruction or a way to help people access these services? Not a lot of folks know this new modality. It is a great direction for all of us, not just people with disabilities who have been doing this for some time. Many of my peers are uncomfortable going into clinics right now because of law enforcement presence. I want to recommend that we utilize peers as part of the deployment process and teaching about the modalities. Also, this is a 30th anniversary of the Americans with Disabilities Act, so can we highlight the way accessibility has to be part of this new modality moving forward? When we make things accessible for some, we actually make them accessible for everybody.

Jacey Cooper, DHCS: We definitely want to make sure we are taking those types of things into consideration as we look at this policy moving forward.

Rene Mollow, DHCS: We did release a beneficiary letter last month that went out to both managed care and FFS heads of households. Part of that also gave them information on the use of telehealth and what to expect if their provider uses that modality. It is something we want to promote and see used, making sure that it is done in an appropriate manner and ensuring the quality and safety.

Kim Lewis, National Health Law Program: Related to the 1115 Disaster Waiver, it does seem to be taking a long time. Do you have any ideas about the hold up? Secondly, my understanding is that HHS is going to continue the public health emergency. Did you have communication from CMS on that?

Jacey Cooper, DHCS: On the Disaster Waiver, I agree it is taking a long time. We did ask for some significant items so I have asked that they approve what they can. We did hear that the federal government will extend the public health emergency. We have not seen that happen yet, but it was communicated to state Medicaid programs that it should be forthcoming. We are waiting for that and hope that will get us through another 90 days of the public health emergency.

Kim Lewis, National Health Law Program: I want to put a plug in for getting data from managed care plans and mental health plans and programs on utilization and how it has changed in COVID and with telehealth. Also, I hope we can look at texting as a telehealth modality as it is in other states.

Rene Mollow continued her presentation with an update on the Medi-Nurse line implemented during the emergency. The Medi-Nurse line offers 24/7 advice and is designed for people without health insurance or who have FFS Medi-Cal but don't have a regular doctor to oversee their care. Medi-Nurse is not designed for callers who already have a health plan that covers COVID-19 services. The Medi-Nurse line is available in threshold languages supported by the Medi-Cal program (Spanish +17 additional languages). Callers can ask questions about COVID-19 symptoms and get referrals to resources. Callers who present with COVID-19 symptoms will also have access to trained and knowledgeable nurses for clinical consultation and triaging, such as how to self-isolate and perform home self-care techniques and how to get tested or seek treatment, incuding referrals to COVID-19 resources such as testing sites using the locator tool via COVID19.ca.gov. If callers present with COVID-19 symptoms, they are transferred to a trained nurse for clinical consultation and triage. Uninsured callers are also referred to a qualified provider in the caller's county who can perform presumptive eligibility (PE) determinations to provide temporary coverage for COVID-19 testing and treatment services. Since the launch in May, there have been over 11,000 calls and 81% were uninsured. Ms. Mollow also reviewed data by county and demographics. We are looking to do outreach regarding Medi-Nurse. We have used our social media platforms to help get the word out and referenced it in the beneficiary notice. We are working on outreach materials for others to share this information.

Questions and Comments:

Hector Ramirez, Consumer Los Angeles County: I want to thank you for this nurse line. We have been promoting this service through food pantries and grocery stores, especially ethnic grocery stores in Spanish communities. I personally have seen how this is being utilized, especially for Spanish speaking communities. I commend the effort and support more, since health care and food are key things people are reaching out for right now.

Rene Mollow, DHCS: Thank you.

Veronica Kelley, San Bernardino County: Are the nurses on the line going to be fluent on mental health and addiction? I know for COVID there are interactions that might be important for a nurse to know when they are providing resources or advice.

Rene Mollow, DHCS: We will follow up on that and get back to you.

Jacey Cooper, DHCS: We did an RFI to identify a vendor who does nurse advice lines and are using a contracted vendor for this. They typically are trained in a number of clinical areas. They have broad training and have access to a physician for consultation. We will take your question back about that particular competency.

Kelly Pfeifer, DHCS: Later, Jim Kooler will go through what we are doing to coordinate across the different programs so if there is a caller on the Medi-Nurse line who needs counseling support, they could be connected to the COVID line we created. And there are access lines available for crisis. We are trying to make sure all of the resource lines

are coordinating and know about each other, so that one line doesn't have to do it all.

Rosemary Veniegas, California Community Foundation: I'm curious about the 81% uninsured callers – that is almost 9,000 calls. Are they usually in counties with resources for coverage, like My Health LA?

Rene Mollow, DHCS: We do make local resources and referrals available to callers. And we provide information on safety net providers. We want them to at least get enrolled into presumptive eligibility COVID coverage so they have a source of payment for testing and treatment.

Jacey Cooper, DHCS: We have had about 11,000 uninsured individuals sign up for the COVID-specific coverage. We are starting to see numbers increase as word gets out.

Update and Discussion of Plans for Medi-Cal 2020 1115 Waiver Extension for DMC-ODS
Will Lightbourne and Jacey Cooper, DHCS
Slides available: https://www.dhcs.ca.gov/services/Documents/071620-BH-SAC-Webinar.pdf

Ms. Cooper provided a high level overview of the one-year extension of the current Medi-Cal 2020 Waiver and the 1915(b) Specialty Mental Health Services Waiver. In October 2019, DHCS released the California Advancing and Innovating Medi-Cal (CalAIM) initiative, a roadmap for change for the Medi-Cal program across all delivery systems. We engaged with stakeholders on those proposals and they were reflected in the January 2020 budget with funding to move forward. The public health emergency hit shortly thereafter. During the public health emergency, counties, providers, hospitals, plans and other stakeholders let us know that due to their immediate response to COVID-19 and the significant changes proposed in CalAIM, they would not be able to engage in successful planning and implementation of a new waiver. We heard that and reached out to CMS to extend the 1115 waiver for one year in light of COVID-19. This extension is reflected in the state budget to delay CalAIM funding for one year.

In order to extend the 1115 Waiver, we have to submit a formal proposal and the proposal triggers certain federal requirements. The 1115 extension proposal will be released on July 22 for a 30-day comment period to close on August 21. The goal is to submit the 1115 extension request to CMS by mid-September.

She reviewed the various Medi-Cal 2020 1115 waiver extension requests that require approval for extension:

- Medi-Cal Managed Care
- Whole Person Care
- Global Payment Program
- Drug Medi-Cal Organized Delivery System
- Low-Income Pregnant Women

- Former Foster Care Youth
- Community-Based Adult Services
- Coordinated Care Initiative
- Dental Transformation Initiative & Designated State Health Programs (DSHP)
- Tribal Uncompensated Care
- Rady's California Children's Services (CCS) Pilot

We want to make you aware we will not move forward the Public Hospital Redesign and Incentives in Medi-Cal (PRIME). PRIME will move to the Quality Incentive Program (QIP). It was always the vision to transition PRIME to QIP and we have already been working on this with CMS. We will propose to continue the Whole Person Care (WPC) pilots with COVID-19 modifications. Additionally, we will ask for one year of funding with rollover in the WPC pilot, extension of the Global Payment Program (GPP) and the Safety Net Care Pool (SNCP) and the Dental Transformation Initiative (DTI).

She reviewed the Drug Medi-Cal (DMC-ODS) extension for the county-based initiatives that support the substance use disorder services and Institute for Mental Disease (IMDs) as listed below. The guiding principle with CMS is to make minimal changes in the extension proposal. This is one area where we are proposing changes that we consider technical changes, although not the larger changes proposed in CalAIM. The request includes a one-year extension for county-based pilots, including expenditure authority for residential SUD services in IMDs. Technical changes include:

- Remove limitation on the number of residential treatment episodes that can be reimbursed in a one-year period.
- Clarify that reimbursement is available for SUD assessment and appropriate treatment even before a definitive diagnosis is determined.
- Clarify the recovery services benefit.
- Expand access to Medication Assisted Treatment (MAT).
- Increase access to SUD treatment for American Indians and Alaska Natives.

There are items in the waiver considered budget-neutral and others that are not budget-neutral. There are no proposed changes to the rules on how things are financed or what draws down federal funds with the extension. It is a total of $300 million of federal funds for the additional year under WPC, one year of funding for GPP and the Safety Net Care Pool. In addition, we will continue items that were previously considered budget-neutral.

On May 8, DHCS submitted a formal request to extend the current 1915(b) Specialty Mental Health Waiver to December 31, 2021, to coincide with the 1115 waiver. The existing 1915(b) waiver was set to expire on June 30. On June 2, we received a 6-month extension from CMS through the end of 2020. CMS acknowledged the need for the additional extension due to the delay of CalAIM and COVID. However, they want additional discussion because it is uncommon for them to do an 18-month extension on a waiver without discussions regarding expectations for that additional year. We have yet to have those conversations. DHCS is now seeking a second extension to the 1915(b) waiver to December 31, 2021, to coincide with the extension request for the 1115 waiver.

The timeline for submission in mid-September is:

- 30-day public comment period will start on July 22, 2020
- Waiver extension request & all other documentation will be posted on the DHCS website
- Comments made at public meetings will be transcribed
- Written comments can be submitted to 1115waiver@dhcs.ca.gov by close of business on August 21, 2020
- Written comments on the 1915(b) waiver extension can be submitted to MCBHD@dhcs.ca.gov by COB on August 21, 2020
- Tribal Consultation (held via webinar)
    - Wednesday, July 29, 2020
- Public Hearings (held via webinar)
        - Friday, August 7, 2020 3:30 p.m. – 5 p.m.
        - Monday, August 10, 2020 2 p.m. – 3:30 p.m.

Questions and Comments:

Linnea Koopmans, Local Health Plans of California: Can you remind us what the timing and processes for CMS to approve or give any feedback on the proposed extension of the 1115?

Jacey Cooper, DHCS: After we submit, CMS will go through the federal checklist to make sure the requirements are complete and then they have their own public posting and process. Following that, there is back and forth negotiation with CMS. We anticipate that we will not have approval of the 1115 waiver one-year extension by the end of this year. There are some budget-neutrality and other issues to work through with CMS. We have proposed a few new items under the DMC-ODS they will have to evaluate and review, and there may be some negotiation. If we were to go beyond the waiver period, we anticipate CMS would give us small incremental extensions as we continue those negotiations before, hopefully, granting the one-year extension we are requesting.

Gary Tsai, MD, Los Angeles County: I want to thank you for the proposed changes in the extension of the waiver for DMC-ODS. I didn't see a mention of maintaining or doing away with the current residential length of stays. Is it correct to assume that those would stay while DHCS also requests from CMS that the residential episode caps be removed?

Kelly Pfeifer, DHCS: We are looking to CMS to ask permission to lift the cap in the extension. I will review the language and follow up. Can you submit a request so I can confirm?

Rosemary Veniegas, California Community Foundation: Here in Los Angeles County, we heard that at Project Turnkey sites and some of the quarantine and isolation sites, there is a need for substance use services. Are DMC-ODS services allowed to be delivered at these types of sites?

Jacey Cooper, DHCS: To my knowledge they can be. They can be provided via telehealth and there are a large number of behavioral health services that have authority

to be mobile and in the community. We are seeking some clarification on certain behavioral health facility types for alternative care settings, but I don't believe there are issues with SUD services being provided in the community.

Kelly Pfeifer, DHCS: There are many nuances with provider types. We have been able to meet most everyone's needs. If there are providers with questions, they should reach out to Janelle Ito-Orille for help.

Kim Lewis, National Health Law Program: Are you asking CMS to continue the existing Special Terms and Conditions (STCs) in the 1915(b) Specialty Mental Health Waiver or are you asking for changes?

Jacey Cooper, DHCS: From our perspective, since we are still working on them, we proposed to extend, as is, the STCs. CMS indicated they want to discuss the STCs and expectations for the one-year extension, which is one of the reasons they split it into a six month and a 12-month extension. We have not had those conversations with CMS yet and will share the information back once we have had those conversations.

Michelle Doty Cabrera, County Behavioral Health Directors Association of California: Looking back to January, we appreciated the work put into envisioning an improved behavioral health system under CalAIM and the associated budget proposal. We are looking forward to moving forward with as much of that as possible at the end of next year. While we think many of the CalAIM proposals would be challenging to pull off at this time with the pandemic, the one piece that we really want to see move forward, if at all possible, are the proposed changes to medical necessity. There are a lot of details around medical necessity that are baked into the 1915(b) waiver and which unfortunately constrain our ability to appropriately claim for medically necessary services to children. If there is a window of opportunity to make those changes ahead of the end of next year, we would love to partner with DHCS on that.

Jacey Cooper, DHCS: We want to move forward with the medical necessity changes on behavioral health as a whole and especially on the mental health side. We will continue to evaluate our ability to do so before January 2022 and look forward to partnering.

Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Centers: Can you elaborate on the DMC-ODS technical changes?

Jacey Cooper, DHCS: There will be more detail in the actual proposal posted on July 22 and you will be able to see details to respond to then.

Kelly Pfeifer, DHCS: We welcome your feedback. We are proposing that eligibility for residential services be determined by medical director or licensed health professional based on medical necessity. Our goal for an average statewide residential service length of stays would be 30 days, but we don't want an arbitrary limit. We want it to be based on medical necessity, and we want to lift the requirement that people can only have two non-continuous 90-day stays.

Chris Stoner-Mertz, California Alliance of Child and Family Services: I want to echo the need to continue the efforts around medical necessity. And, I would add that whatever we can do to improve access to substance use services for children through EPSDT is a significant need.

Jacey Cooper, DHCS: Yes, we don't need any additional authority to expand under EPSDT and we continue to look at how to expand access to SUD services to children. It is important to me and I look forward to working with you and others on that.

CalHOPE: Crisis Counseling Program Update
Jim Kooler, DHCS
Slides available: https://www.dhcs.ca.gov/services/Documents/071620-BH-SAC-Webinar.pdf

Jim Kooler presented information about the CalHOPE program. The pandemic and physical separation have created isolation, medical issues, employment concerns, housing insecurity, and food insecurities, all leading to stressors that make us feel anxious, potentially depressed and can lead to long-term behavioral health issues. To get ahead of this with preventive efforts funded through FEMA, we are implementing the Crisis Counseling Program (CCP) program, first used during the fires in Butte County. There are two phases. The Immediate Services Program (ISP) is for the first 60 days after the declaration of the emergency. We were fortunate to receive $1.6 million from FEMA to relaunch the CalHope campaign to focus on normalizing feelings of stress and anxiety, assisting people, and referring to higher levels of service when needed.

Part of the effort is a media campaign, such as digital pop-ups on phone or computer. There have been 12 million digital impressions, 89 million on television and 10 million in Chinese language content. And, 2.3 million people clicked on the pre-video with 92% watching the entire video. Also, 9,400 people took actionable steps to connect to the website and then connect to someone who would help them. Interestingly, the Spanish language response was twice the general public rate.

For many, the social media is enough. Others go to the website for additional resources. There are a number of tools around mindfulness and connections to other resources and apps. On the website, there have been 26,000 visits, with 16,000 new users spending over two minutes on the site. The Chinese ads generated over 6,000 visitors to our site. A Warm Line is also available for more in-depth help and we are seeing 50 to 60 calls per day. Dr. Kooler then took members on a virtual tour of the website.

Those are all part of the ISP. We also have an application into FEMA for $84 million for the next nine months, unlike anything FEMA has seen before in its scope and scale. We are proposing a statewide response in partnership with California Behavioral Health Directors Association, California Mental Health Services Authority, and University of California for an expanded investment in media and a website with a human centered experience for people to find the assets that will help them most. Another addition is a program to connect for up to six sessions with someone to guide them to the support needed. We have a specific contract reaching out to American Indian/Alaska Natives.

Finally, we are looking at schools to connect and support young people and families. With distance learning and young people at home, parents are frontline responders, having to be teacher, parent and employee at the same time and it is challenging. We hope all of this will become available through FEMA funding. We submitted the application on May 21 and expect to hear any day.

Questions and Comments:

Jei Africa, Marin County Health Services Agency: Are you seeing data trends for the specific types of calls or where they're linked? Are there trends on the kinds of people or communities that are calling?

Jim Kooler, DHCS: Our line is too new for good data at this point. We are receiving calls from across the state. Many calls are about stresses and the basics of food and employment. There is not sufficient data to report on behavioral health issues. We hope to have more information in the future.

Children's Behavioral Health Listening Session for Future Planning and Discussions
Kelly Pfeiffer and Jim Kooler, DHCS
Slides available: https://www.dhcs.ca.gov/services/Documents/071620-BH-SAC-Webinar.pdf

Kelly Pfeifer presented on access to behavioral health services for children and youth, beginning with the goals:

- Right care, right time: Every child or youth with behavioral health needs will have timely access to high quality care.
- Meet needs of children and youth in foster care: Ensure coordinated, cross-system, trauma-informed health care for children in the child welfare and foster care systems.

CalAIM aims to make specific improvements to improve systems in behavioral health. For example, we aim to improve coding and data analytics as building blocks to ultimately move beyond cost-based reimbursement to linking payment to value. There is a lot of foundational work to get to value-based payments. So that, if we have another pandemic, we are not in a system of cost-based reimbursement where sudden drops in service volume lead to providers' financial instability. The second big piece is integration to allow better care for youth with co-occurring disorders. We have heard from you about the challenges of requiring separate diagnoses - either a mental health issue or substance use disorder. We have heard that the current ways of determining medical necessity and the way we divide the work between managed care plans and mental health plans also is creating challenges. We have had many conversations about how to address barriers to treatment, improve coordination between managed care and specialty mental health, allow services prior to diagnosis, and ensure EPSDT protections. We want to make sure that the promise and protection of EPSDT is in place and we are working hard to make sure there is maximum flexibility with no barriers to services, including for children being served in school settings.

During the pandemic, we want to ensure maximum flexibility to provide children and youth with access to services. Post-pandemic, we want to leverage what we learned, so we keep what works and build on improvements. Telehealth has great promise, but we also realize telehealth is not the only answer. We have interesting data from LA where they did focus groups and interviews with youth and found that youth have concerns about privacy.

Over time, we have we are aiming to build a robust set of metrics to hold counties and managed care plans accountable to standards for access and quality. Network adequacy metrics include time and distance, timeliness of appointments and provider ratios. We are tracking penetration rates to make sure the kids that need it are getting care. We track quality metrics as well as grievances and appeals. We are working on a public mental health dashboard and are also developing a SUD dashboard, which has been slowed due to the pandemic, but we're really looking forward to sharing those data. We are continually building out the open data portal with new reports so there are more data reports available to the public.

We also use functional assessments because utilization data only tells us whether a child or youth receives the service, not if they are actually improving. We are working on new tools and continuing to work on the reporting and oversight structure so that we have a way to leverage the data.

And finally, there is a suite of work happening to meet the needs of youth in the foster care system.

- AB 2083: Better coordinate between county and state agencies, focused on trauma-informed practices.
- Therapeutic Foster Care: Implement and scale model (as of June 2020, there are 12 TFC providers approved and 11 providers awaiting Medi-Cal certification).
- Pathways to Well-Being (Katie A.): Ensure children and youth have access to coordinated and intensive home-based treatment services.
- Family Urgent Response System: Implement statewide hotline and county mobile response to allow prompt intervention and issue resolution for children, youth in foster care and their families.
- CalAIM Foster Care Model of Care Workgroup: Evaluate options for better and more reliable health care for children and youth in child welfare.

Dr. Kooler introduced the listening session input by asking for members to share their thoughts, especially on the following questions:

What else should we consider?
What ideas do you have to improve quality and access for children and youth?

Questions and Comments

Kim Lewis, National Health Law Program: We share those goals and have been working on trying to achieve them for many years. I'm interested in understanding how this fits

into what has been a pretty robust and detailed conversation around CalAIM and the timing of changes and improvements in the system, including more detailed and better data, not just the things listed but also utilization overall between the health plan and the mental health plans, children in specialty mental health and more. As a population, utilization is probably not that high. With a bifurcated system, how do we look at children across multiple systems to address their needs before they have high-end needs and end up touched by child welfare or the justice system? I'm trying to think about how we are serving them so that they do well. Prevention and early intervention.

Michelle Doty Cabrera, County Behavioral Health Directors Association of California: It's a bit of a myth that children with unserved needs on the behavioral health side end up in the child welfare system. There are multiple drivers and primarily poverty at play there. We need to better identify and meet kids where they're at. CBHDA had a legislative proposal before things shifted due to COVID to extend partnerships within schools and better serve children through early identification. The medical necessity conversation is extremely relevant here because access or quality through a medical lens alone is a partial picture, particularly given that Mental Health Services Act funding has filled in many gaps through prevention and early intervention programs, including services to youth who may not technically meet the medical necessity criteria. The early-psychosis programs have been funded almost exclusively under MHSA funds. We need to do more within Medi-Cal to realize the benefits. There's great opportunity under the foster care work group to improve the scope and the quality of services that County Behavioral Health is responsible for providing to intervene early. One issue not flagged is children with acute high levels of needs. In our networks, inpatient hospitals and other providers do not serve very high need youth. There are significant concerns around the workforce. Initiatives in other states infuse more trauma informed practice into provider networks. While we've had conversations about trauma from the vantage point of primary care, we need to apply that lens in the behavioral health space.

Ken Berrick, Seneca Family of Agencies: Building off what Michelle said, we also have to define levels of service. We have done work on this, but we're stuck and that is why there are places where kids can't get access to the care that they need when they are most vulnerable and acute. First, we have to define what that continuum looks like and then second, particularly for smaller or midsize counties, how we can work together to make sure that those services are available. Counties frequently reach out to me to say they don't have access to the highest levels of care and are too small to build them. It is frustrating because we want to be able to serve, but we can't without a more collaborative and coordinated statewide effort. So -- clarifying that continuum at a high standard and how counties can get access. We are not talking about a lot of spots for service, but we are talking about desperately needed services.

Veronica Kelley, San Bernardino County: Both Ken and Michelle said it well. We have a paucity of services available for our children at the highest end. We have kids who need something akin to a state hospital bed and we don't have that. We don't have acute beds available for us to address the child's immediate problem and then also build family resources. Counties are good at a lot of things that are super complex, including our ability to leverage funding streams with education. In San Bernardino County, we developed a system with education dollars as match to draw down federal funds and

expand our footprint by using MHSA dollars. To look at us under the microscope, only from a Medi-Cal lens, isn't the full scope that the county brings to the table.

Al Senella, CA Association of Alcohol and Drug Program Executives/ Tarzana Treatment Centers: I want to echo the discussion on telehealth texting access and keep on the table that technology tools do come with barriers. Also, when we talk about access around substance use disorders and co-occurring disorders, there are a lot of resources poorly used. They go unused. And I say this based on very direct experience in the substance use continuum. Under the ODS system, many counties reach out to fund residential providers and even though the contracts are in place and the service is there, they can't be utilized because the referral into those services is next to nothing. And it's only gotten worse in recent years. So, something is broken in our system. That is something we all need to bring into the discussion and study.

Jevon Wilkes, California Coalition for Youth: We need to get youth involved. We need their voices at the table. The only way to make this better is to give them decision making ability and incentivize their engagement, their accountability to themselves and their peers, because they are the consultants to a better system to support them.

Hector Ramirez, Consumer Los Angeles County: I am a consumer and I think the elephant in the room here is pretty obvious. If we want to talk about improving behavioral health care for children and youth, it is important that we begin to address and actually label racism as a public health crisis and find tangible solutions. We are all witness to this right now and that is the intersection that needs to be addressed as we develop new plans. I am hopeful that CalAIM will begin this work. The Surgeon General's work around ACEs highlights the way racism, either intentional or unintentional or generational, has had an incredible impact on physical health, mental health, and community health. I hope that as DHCS transforms under COVID, it realizes this is a great opportunity to address the issues impacting us as priorities. Medical necessity also ties into this as well as getting young people involved. California is diverse and racism should not have to be a tradition of our great state of California. I wonder if we can declare racism a public health crisis as a solution to address and improve the behavioral health care for children and youth. As our children are trying to survive, we can't give this to them anymore. We have to be brave and do something for them by addressing this.

Jei Africa, Marin County Health Services Agency: Thank you, Hector for your comments. I know that there is a lot of work to do, and that's why we're having this conversation, and counties have really been thinking about how to engage young people in this process. In community planning processes with MHSA in Marin County, we have looked at how to engage young people through investments in leadership for young people in all sectors. And ask them, what kinds of providers they want to see and what scope of work? There is a generational difference in how we see services and what kinds of services are appropriate through youth eyes versus adults. We need some creativity. I also think partnerships are needed. We have been very fragmented in how we do our systems and the way we respond. The reality is each organization, each service has their own culture.

Chris Stoner-Mertz, California Alliance of Child and Family Services: I couldn't agree more. We need to look at how we use MHSA dollars that may be used creatively for

things like peer services, and what the barriers are to providing those in Medi-Cal. Let's think about how the current system is constructed with all of its racial bias from a medical model and how we change the system to address youth needs. The hope is that foster care coordination under AB 2083 is going to improve integration and we want to move that forward quickly. And we have to address the issue of administrative burden. There are discussions about doing that in CalAIM, but we can improve now without CalAIM, as it relates to what is required for documentation and who can provide those services, who needs to sign a progress note. Finally, we have to look at financing and utilize every possible local and state dollar to match Medi-Cal funds because we are in scarcity mode.

Gary Tsai, MD, Los Angeles County: I appreciate DHCS for this discussion to invest energy in youth systems. I agree with the importance of getting input from youth to develop and construct a redesigned, renewed youth system. This approach has been effective with media campaigns and a similar approach can be used here to design user-friendly youth systems. Engaging youth has been a fundamental challenge and a reason why penetration rates are not where we want them to be. We would benefit from DHCS' partnership in identifying and resolving some of the key barriers, such as those Al mentioned. Youth residential referrals from the criminal justice and probation systems have gone down significantly. There is a reduced desire to refer youth to institutional settings. We need to adapt to work with the non-behavioral health systems as they evolve and impact referrals into the behavioral health system. Also, we need DHCS to clarify how counties can leverage contingency management to help support care for youth. It is evidence-based, a way for us to engage youth that doesn't have to be monetary incentives to treatment. Finally, clarifying EPSDT. We get questions about EPSDT for SUD-only youth. I also see responsibility on the county and provider side to stop creating barriers and use the flexibility we have. Creating a forum to hear about creative solutions to engagement would be extremely beneficial.

Kelly Pfeifer, DHCS: Can you clarify what you would need from the state on contingency management? If it doesn't involve financial incentive, you have flexibility to implement this practice.

Gary Tsai, MD, Los Angeles County: Yes, and we let providers know that there isn't a prohibition with contingency management, but we need to make it crystal clear about how to operationalize it. We have done that at the local level but given the questions we get, it would be helpful to have the state clarify. We know that the waiver renewal will incorporate contingency management as a recognized evidence-based practice from DMC-ODS, so that's what I was referring to.

Catherine Teare, California Health Care Foundation: I have additional asks related to data. We know anecdotally and thanks to the California Community Foundation, we have data that leads us all to be concerned about the survival of smaller providers, particularly on the SUD side, but also on the mental health side. With that in mind, we need better data about what's going on with our providers as soon as possible. That can be collected in a number of ways, but I hope it can come up through DHCS to get a good picture of where children and youth are currently seeking and receiving care. In addition, we need to start planning for what we are going to do in the event that not all of our providers are here in a year. We need to be able to identify what is available on the managed care plan

side and what is the capacity of FQHCs to serve children and youth. And then back up to the beginning of our conversation about who is doing telehealth and what youth are receiving telehealth services? What is working and not working from the perspective of children and their families and from young people directly? And finally, when we talk about systems, could we integrate information on minor-consent mental health services?

Rosemary Veniegas, California Community Foundation: Our colleagues at the Youth Policy Services Group have uplifted the data just mentioned. My question is, what do time and distance mean in terms of adequacy and access in the time of COVID? In LA County, folks are looking at what the abandonment rate means. How many attempts is the limit in terms of the number of times that a youth or their guardian or care provider need before they stop trying? I chair the Hospital Commission for LA County and have heard from fellow commissioners that when they tried to visit sites serving foster youth, there's a sign up that says, "I'm sorry, the hours are very limited or no one is here." Customer service response has been very slow. How do we engage the tools that we already have to look at provider experience, administrator experience, and youth beneficiary experience? I support the idea around data because time and distance and adequacy have become very challenged.

Will Lightbourne, DHCS: Although this is an input time for stakeholders, I feel I am new enough to DHCS that I can almost still call myself an outsider. I want to offer thoughts that I hope become priorities. We need clarity on medical necessity. A particular sensitivity I bring is penetration rates for children in foster care. If we detected an absence of bonding between caregiver and child, we would consider it an impairment. We would not consider it a diagnosable condition of the child, but an impairment needing mitigation and healing. In foster kids' placement settings, there is an absence of bonding. And so, recognizing the need to bring interventions like parent-child intensive therapy that we know work and likely would use if it was an intact biological home. We have to consider that it is probably needed in the majority of cases. It shouldn't be a subset getting specialty health but be prepared to say it needs to get to be almost the universe.

Jevon Wilkes, California Coalition for Youth: When I think about young people coming from the system, being involved as a young person on the streets, behavioral health, experiencing homelessness, I think a low hanging fruit is that most of these kids are a part of the system. At what point do they have any opportunity to provide feedback? At the critical time that we are in with COVID and other pandemics of racism and justice, I am continuously trying to uplift our youth. Have we thought about something on the lines of a point-in-time count for young people within systems? Do they have incentive to provide input to the system? This is an opportunity to grab onto some of the voices we have access to as a high need. I bring that up as someone from the system and now being on this side and having family members currently having to navigate the system.

Michelle Doty Cabrera, County Behavioral Health Directors Association of California: Have we provided them with an opportunity to provide feedback? We have these young people within our care, and I think sometimes it's letting down that ego and just saying, "We're all trying to be better." And we need these young people's feedback. I would be remiss also if I didn't call out the implications of COVID-19 within this conversation. Aside from the individual level of collective trauma that everyone is experiencing right now, this

is a profound moment for young people. And, as a state, I would be remiss if I didn't call out the fact that we really need to do a better job moving forward of making concerted investments in the behavioral health needs of children who are covered under Medi-Cal. We cannot continue to underfund, relative to other systems, our public behavioral health system, and expect it to do all the things that we want it to do for children and youth. There is a lot of creativity happening, but that will only take us so far. This is a plea that when we get into our next budget cycle, we need to do better on behalf of youth in Medi-Cal, to realize the great ideas that so many on this call have put forward and acknowledge the lasting impacts of what we're all going through right now.

Chris Stoner-Mertz, California Alliance of Child and Family Services: Will's comment brought it to a head for me, that the integration between child welfare and behavioral health is so critical and helps children who have experienced trauma. The more emphasis we can put on family finding, permanency, ensuring that children have healthy adult relationships and a person to turn to. I think sometimes in our efforts to find a place for them to live, we forget how critical that is, yet that is as much to their benefit and mental health as anything else.

Sarah-Michael Gaston, Youth Forward: I want to reiterate what Chris was saying, that relationships are so powerful. Especially with young people, they have the potential to protect young people from harm.

Kim Lewis, National Health Law Program: I am reminded of why we brought legal action many years ago on foster youth and mental health services. It was not just to get those services in place. One thing that CDSS modeled well, in the collaboration that came out of the settlement in that case, is to ensure that there's a core practice that is broader than the child welfare/mental health marriage, but could be a model going forward for all kids -- to have this child and family process, where the youth, the child, the family, is at the center of the planning and the care coordination and management of their needs. They are the strength of the system and they know best what they need. It's important we put them at the center and that they are the experts, the drivers, as opposed to us telling them what they need to have or what works for them. That is a core practice CDSS put out and required statewide.

Rosemary Veniegas, California Community Foundation: I want to express our appreciation both to you, Dr. Kooler and Dr. Pfeifer, for joining us several times in L.A. to talk about what a youth-centered design might be in terms of substance use services and the systems of care meant to wrap hearts and minds around young people in our communities. I appreciate the journey you are taking with these ideas.

Dr. Kooler closed the session by encouraging everyone to send comments. I appreciate the richness of the discussion and the willingness to put ideas out there and wrestle with them. We are always open to more comments and ideas. We want to hear from you as we move forward on this journey to improve the systems that support young people and families to have the kind of future we want them to have.

Public Comment

Nicole Scanlan, Cal Voices and the Office for Mental Health Project: I want to echo the caution I heard earlier around telehealth services. The expansion of telehealth services both prior to and during the pandemic has been vital to increasing access to mental health services, especially during the time of physical distancing. But as we know, there are many people left behind due to lack of technology access, in terms of equipment and broadband and strength, but also due to the capacity to use these systems. We know that those living in poverty don't have the same access to technologies as those who are in affluent areas and this disproportionately impacts black and brown communities. In addition, folks living in rural areas may have access to the necessary equipment, technology, computers, tablets, whatnot, but may not have fully functional broadband that can handle WebEx, for example. And from an LGBTQ perspective, we know that many LGBTQ youth sheltering in place in houses that are rejecting of their sexual orientation and or gender identity. We have heard stories of youth who have had to find creative ways to participate in their social support. One story involves a youth sitting in the closet using a chat function so that their parents don't know that they are participating in an online LGBTQ support group. The move to technology for services is not a panacea for all. Any additional steps the state can do to help bridge the digital divide will greatly increase access to all virtual services for all people. And on the LGBTQ point, we would just encourage the administration to work with community leaders, to identify safe strategies for LGBTQ youth, living in rejecting homes, to be able to access any type of virtual support in the public mental health space.

Amparo Ostojic, ACCESS CALIFORNIA: This initiative on telehealth will be really helpful for many settings. However, my mom is a dentist and I worked with her for a few years back in high school. And when that information came up about possibly getting telehealth in dentistry, I immediately called her and asked for her perspective. She works in an organization that serves Medi-Cal, and she was pretty shocked that this would be an option because she didn't see this being usable in any way, shape or form. Apparently Medi-Cal pays from around $95 to $225 per hour. And then to have that billing available for a video consult or a phone consult – it seems the only possible service that could be, maybe useful is, perhaps, the prescribing of medication to temporarily ease inflammation or something like that. And she mentioned perhaps pregnant women would benefit from counseling on what to do in terms of dental service, but for anything else, it would be really hard to see how it could be a benefit. It could potentially lead to more fraud. It could lead to misdiagnosis of conditions that could escalate and become a bigger problem. So this is a really big thing that stood out for me, and I'm not sure how many dental or dentist community folks have been invited to this conversation. It's important to have that conversation because I really don't think this modality translates into dental services.

Le Ondra Clark Harvey, California Council of Community Behavioral Health Agencies: Welcome to our new director and thank you to DHCS for your advocacy to include key safety net programs, such as Whole Person Care, in the waiver. At CBHA, we appreciate your openness to examining the expansion of telehealth during and after the pandemic and applying for federal funding to support California through programs like CalHOPE, which was covered well today. And I also agree with the comments that were made by members about the need to look at which components of CalAIM we can move forward with, including changes on medical necessity, integration and paperwork reduction.

Chris Miller: I am a resident in the San Jose area, Silicon Valley. I was a former member of the Interagency Prevention Advisory Council that was folded into this advisory group, and I served on a suicide and depression prevention work group. That work group focused on outreach to faith leaders. As many of you know, the national co-morbidity study has consistently shown in national studies that those suffering with mental health disorders turn first to a faith leader over any other professional or clinician. I have attended the DHCS Substance Use Disorder Conference the past several years and was excited to hear two years ago from a faith leader, talking about the role of faith, especially in 12-step recovery programs. I am currently a member of the steering committee of the California Mental Health and Spirituality Initiative, a non-governmental effort of faith leaders and clinicians across the state. It was my understanding that the previous work groups were folded into this group. Given that, what conversations has this group had around the role of spirituality? Are you open to having that conversation?

Will Lightbourne, DHCS: Let us take that back to evaluate where we address that in the work going forward.

Carol Brown, Statewide Foster Care Task Force and Alameda County Child Welfare: I want to echo the comments made today. Almost everything I was thinking has been touched upon. I want to reinforce the need for better data. Not only whether children get into services, but the outcomes; what the services produced. Some needs we have right now are when we transfer kids from county to county and make presumptive transfers to behavioral health care. I'd like to work with Michelle on getting better responses from the county's access line. We find that when we leave a message, it might take a couple of calls and maybe a week before we get a response, which didn't used to happen. So we had a few children, one in LA, and I'm not sure she's received therapy yet. And there is an issue with Medi-Cal foster youth that when they're released from inpatient hospitalization, there's no place for them to go. We've had a few children and family team meetings, as well as a meeting with a grandparent of a teenage youth she was legal guardian for, who was being released from hospital and there was no place for him to go. I was looking for resources and I did find one place that might've worked, but I don't know what happened there. We have COVID-19, everything's a crisis, and we don't have a lot of time for planning. And there isn't a system in place to take these children on a regular basis. We need to figure out what we do with children when we have to leave an inpatient hospitalization for mental health services.

Makala Bouchard, California LGBTQ Health and Human Services Network. We would like to recommend the following requirements be implemented within the CalHOPE program and would be happy to provide technical assistance and implementation. The first thing is to require that all CalHOPE providers receive extensive training on how to support LGBTQ community members. The next thing to require CalHOPE to contract with local, trusted LGBTQ community providers for warm handoff services that provide consumers with accessible and safe support within their community. Also, to specify LGBTQ community members as a part of the high risk group list in need of culturally responsive care. And finally, to ensure that LGBTQ people of color are represented within CalHOPE staff.

Jeff Farber, Helpline Youth Counseling: I serve as the chair of the Youth Services Policy Group. I want to thank all of you for taking the time to look at the survey that we submitted in partnership with UCLA and others. The need for youth voice at this time is so important. The impact of COVID-19 on youth has brought forth the inequities in the service delivery system. And I think that we are, as many of you said, at a crucial point in looking at how we can best support youth that is in my mind a number one priority. I thank you for your leadership, for your belief in a youth-centered system of care. And we want to express our interest as a 22-member collaborative of SUD prevention, intervention, and treatment providers in LA County to partner with you to improve access and to improve the system of care for youth so that all youth have the opportunities for the intervention and treatment services so crucial in their lives.

Denise Tom, California Community Foundation: I work with Jeff Farber as well as Rose Veniegas and want to thank all those who made comments about telehealth, but I would urge that the discussion should be wider and broader. It should be about connectivity. And it's great that the health system is trying to integrate services, but it also needs to integrate with other systems like the education system. I just worked with our education team here on a summer online learning initiative. I know there are efforts with the Governor's task force to bring connectivity to California. And in LA County, 39% of Latinos and 36% of African Americans don't have access to connectivity. Whatever DHCS can do to align their efforts on telehealth to the statewide effort on connectivity would be most appreciated.

Next Steps and Final Comments; Adjourn
Will Lightbourne DHCS

I want to extend my thanks and appreciation to all of the stakeholders and the public who joined this afternoon. As you see from the presentations, there's a great deal of work in process and we'll be doing everything we can to keep things moving forward and restart initiatives as quickly as we can that may have been pulled due to the public health emergency. As we do that, we're going to be doing it through the lens of creating equity and in a more fair and just society. That is our commitment to you. Our next meeting is October 28, 2020, 9:30 a.m. -12:30 p.m.