>> It is 1:05 so I'm going to go ahead and call our meeting to order. Thank you, everyone for joining us here today. This is the first meeting of the project Bravo racial equity workgroup. If you're here you either nominated yourself or were nominated by one of the colleagues to participate in this conversation to address equity as we move forward with enhancement of behavioral health services for our common law. My name is Alissa ward. If I can move the slides forward. I'm a clinical psychologist and behavioral clin dal director at DMAS and it looks like Laura, what is our total number of participants right now? . >> We v30 total. I'm mindful I've been participating over the last year and so many of these very large conversations. With lots of people in them. Doing these on Zoom can have strengths and challenges and can talk a lot of time but also be rather clunky and impersonal. So I wonder if perhaps what we could do for today is if folks could put your in the chat as a way of introduce ugh yourself and hopefully we can break into smaller groups where we can have more meaningful introductions with each other. I can already see by looking through the names that we have representatives here across a number of different collaborators and stakeholders. I to acknowledge Laura Reed cohosting and running the WebEx meeting today who is behavioral health senior advisor. Thank you, Laura. I also see quite a number of our internal DMAS team here today and I want to acknowledge and thank all of them for being here today. Katherine cross by is here today listening and then we have a number of our partners from DBHDS who are also able to be here today. And then I see a number of community members and stakeholders behavioral health providers from across -- it looks like all different sectors of the system. Our behavioral health service authorization vendor Magellan. So thank you so much everyone for gathering and taking the time today to be here I also appreciate how timely this meeting is given the events of the last year and particularly the last 24 hours. So just want it to acknowledge kind of the context of this space. I also want to thank our captioner here today who will be providing closed captioning for this webinar if you need it. You can link to this service through this link here. It is also pasted into the chat box and you'll be able to get a stream that will provide closed captioning while I or others are speaking Darlene I will try to speak at a very mindful pace. As well for our meeting today. Before I move forward, are there any questions about the accessibility of this meeting or use of the captioning. >> This is Julia Torres Barden representing Mai and I wanted to make sure you're guys can see me. >> I can see you, thank you for being here today. >> I'm new to the situation so I'm not sure of the background or what the goals of the group are. >> We'll be talking about that today. Thank you, Julia it's our first meeting so we'll be collaborating on those goals today and talking about what brings us here. >> Great. So I'm going to move forward with our agenda right to Julia's point. What brings us here together today? We're going to talk a bit about the behavioral heathen enhancement or project bravo initiative. And you know the

goals of this larger vision and how goals of equity go hand in hand with that goal of system transformation. But we're going to start today by you know just addressing psychological safety within these difficult conversations. And talking about some group agreements together. As we move into hopefully what will be a long and enduring conversation around these issues. I have some statistics and overall background to share with folks who are joined here today around kind of the national picture of equity within behavioral health services. With particular scope around access to services and engagement and participation and services. I'm mindful of the space I'm taking as facilitator today and we can get into it and feel through how much of that is interesting and we don't have to cover content today but I have information just to get our brains thinking about the issue. Then we're going to talk and think together about the scope of action for our proposal within this initiative. being part of many of these conversations over the last year and I know many of you have as well, I'm sensitive to the feeling of being in the mire of the space. Trying to find ways to move into conversation and action and purpose of the group can bring about some progress, can hold space for mindful discussion but can also work towards collaborative progress together. And it feels really important to me as the facilitator of this process to assure you that we do want to take action, that we want to come up with actionable and reasonable steps that we can taking together forward even if those are very incremental. And to find things so that we can measure and see ourselves moving forward together. So that balance of respecting need for expression or discussion and then also you know responsibility of moving that discussion into action. We're going to talk about what the actions are for this group within immediate next steps that we may be able to take together. First thing that bricks this particular workgroup into is this big idea about enhancing our behavioral health service system. And the joint team at DBHDS and DMAS have been working together towards that vision for the last two, two and a half years. This vision is around implementing a fully integrated behavioral health service continuum that really allows for our members to have options. Participate in care more freely within their communities and be less reliant often high acuity in institutionalised services and to focus on meeting folks where they're at, where their natural supports exist. We want to try to bring high quality and evidence mif based services into our system and reinforce and sustain their use through appropriate reimbursement. And we want to be trauma informed in that approach. We want to assure that the services that we are bringing online to enhance our -- you know congruent with the cultural needs of the commonwealth. And are reflective of the communities that they would be offered to for participation. And so this ow workgroup really I see as part of that trauma informed process. Of acknowledging that the structures that pay for -- that provide, that work with the systems around healthcare and behavioral healthcare are subject to the historical and systemic racism that is

part of the history of our country. And so in enhancing these services and bringing new services in, it's an opportunity for us to think about how we undergo that process. And to open up a new table to conversation about what that looks like and how we can do better. And so off of that point what brings us here is hopefully amongst us a shared belief that Black Lives Matter and that black mental health matters. I hope many of us are called here todays because we feel a call to take action for impacts of systemic racism and this really complicated world that we share together. I want to say at the forefront of this meeting that I am very obviously and plainly though will identify for you as a white woman. And as ayou white woman facilitating this conversation, I want to own that I have my own anxiety about holding the conversation. But that I know that my colleagues of color that that the people on my community of color have anxiety right now even about driving their cars. Or having their children be out in the community. And so the least I can do is hold space for that and deal with my own anxiety having this hard conversation and leading this hard conversation. >> Alyssa this is Julia can I ask a question politely and gently. I am Hispanic from the Bronx so I want to -- though I lived in Virginia for 20 years, I want to understand delicately is this group multicultural in scope or specific to the African-American community? . >> Alyssa: Thank you for your question. It is certainly multicultural and diverse in scope. Absolutely. >> Okay. >> Alyssa. Really, I put this up here today and I'm acknowledging these things specific to the last 24 hours in many ways with the verdict in the trial and you know even in the subsequent death and murder of Maciah Bryant I want to put this front and cnter to say I'm mindful that these are heavy an intense conversations particularly for those who join us who identify as black and brown people. Acknowledging that I'm a white person and that race is also acknowledging that race is a social construct but that there are many impacts that come from that social construct. And those are what we're going to try to muddle with together. But Julia certainly we -- and actually my next slide will maybe speak to it too. But certainly we have concern for all manner of diversity and -- in the group. >> Okay, thank you. >> Alyssa: So again just saying we are here together to have these conversations if you -- I want to welcome active participation from the group if you prefer to be oncamera, fine, off camera is fine, speaking in the chat is fine. Needing to lead is fine. And we'll talk about more about some of those group agreements. We'll heap to support and acknowledge that moving beyond moving beyond acts of allyship that us as white people and that particularly myself as a white woman in a state government structure and in a division director type position have a responsibility to help to dismantle and rebuild pieces of the system that have been broken. Because we built that system and so I want to be a partner and an ally in the best ways I can. And and that's what I'm growing in the process. I appreciate the feedback of experience of me today and the group today and welcome that personally during or after the meeting. I also want to

acknowledge the movement to stop Asian hate and particularly because some of the data I'm going to describe today kind of elucidate the impacts of some of the xenophobia that we've seerch the last year and beyond of course but how this last year has really impacted mental health on the API community. Of course to not acknowledge Julia, of course, the impacts to folks in this country who you know have come to this country from other places and particularly those who are identifying as Latin X and the impact this year has had on them as well. . >> I want to speak a bit about psychological safety. You know, the Zoom world we're in in some ways I feel like it does allow some safety for us in different ways, right? I'm here in my space, I wish you could be here in this warm room I've created for comfort for myself in this last year. Hopefully we've all created these spaces in our homes. So we're in safe spaces hopefully having this conversation but we're also having it on Zoom which can feel kind of impersonal. And not -- for me sometimes it's hard. I can't see all of your faces or reactions. I don't know exactly how you're feeling or I can't read the normal cues. That makes it really hard for me as you're facilitator. That's why I really want to encourage you know writings to me afterward or sharing in the chat anything that can help provide that feedback if you feel like you're trying to get it through to me but I can't see you to honor it. Or reflect it. I liked this quote from Amy Edmund son psychological safety is a belief that one will not be punished or humiliated for speaking up with ideas, questions, concerns or mistakes. So it's my desire to create that space today but that's something we have to create together and honor together and I hope we can work towards that together and it's not a guarantee when you walk into any space, Zoom or not. Some group agreements that I thought we could start with and I welcome any ideas about add being to these, our first -- as I already acknowledged that race is a social and not biological construct and it was real world implications for us so we have to deal with it. Respecting the dialectic. What that speaks to for anyone who has ever done any -- I know we have behavioral health people here. Anyone done any behavioral dialectic therapy what I meant is respecting the fact that two experiences and truths can be true at the same time because they're true to those individual people and their experiences. So acknowledging that every person here is going to have had a different experience of this day and will have a different experience of this group and will have different opinions and they can be different but they can have insections so they can have similarities but they can also be distinct and they can exist at the same time. And even within us, right? So I can be experiencing both gratitude for the courage of the jury yesterday and the verdict that was held. I can also continue to feel sadness and grief and mourning that the events and murder of George Floyd occurred. If the idea that we can hold different feelings and experiences at the same time. I want to incourage this group to come from a place of curiosity and of compassion for each other. And that actually kind of goes with the bullet point two points

down which maybe I should have lifted up. One way that I do this as a psychologist is to try to think in questions. Sometimes when someone is speaking, we will jump to thinking about our defense or our response but rather than thinking that way I want to encourage us to think from a place of curiosity and questions. Some someone says something what questions does that bring up for us to better understand their experience or their point or what questions can we ask ourselves to understand more deeply what our reaction is? Also acceptance of nonclosure that we're not going to have all the answers here that this is likely to be a difficult conversation we're not going to save the whole world here together. It's going to be uncomfortable and hopefully we're going to make small action steps forward together. Sharing the air feels awkward. I'm just the one talking and I keep talking because I'm facilitator. I'm uncomfortable with it but we want to try to share the air here. So everyone being mindful of the space that they're taking up. I want to encourage the use of oops and ouch. Hopefully you heard these terms before. If you haven't, oops is if you find you say something which I absolutely will in the course of these conversations I'm going to say oops that's not the way I meant to say that. Say it. Say oops like that means whoops I didn't mean that that way and ouch is a good way to indicate to someone when you don't have the words to say how that was hurtful to say ouch. That can give the cue that we tread in a way that wasn't comfortable that was hurtful. So just want to include those but I open this up. Are there others that you all would like to put forth today for this space that we're going to share together? What do you think? I'm going to keep going. talking to the other screen. Laura, if you see anything in chat that I'm missing, would you just give me a heads up? I can't really see it very well. >> Laura can you hear me. >> This is Mary Walter. I Alyssa put that in my comment. I don't think you could see it. The other comment is this sets up a nice foundation to work with. Someone else said that. >> Alyssa: Chats are coming to the screen that I'm not looking at of course. So I'll try to orient my head over there. It's odd they show up and then they disappear. Kind of like comment bubbles. >> We have another comment feeling free to ask questions instead of assuming or making generalizations. Then we have another comment that says I often find myself saying quote I need to rephrase that. Though were good, Julia, I thought I saw you leaning in. >> Curious that I had to unmute myself. You can see us but we can't see you. >> Can you see me? >> No. >> Yes. >> It might be -- Julia, I think you're on your phone so it might be you can see my slides but not me. >> That's it. It depends on the format. The slides take up both screens. That leaves me with no chat so that's why Laura and I are this. >> Alyssa, I wonder if the individual who put in the chat that I find myself saying I need to rephrase would be willing to unmute themselves and provide us with thousand they pronounce their name hello my name is SUmiye. >> Thanks. >> Thank you so much. >> Thank you. >> Thank you. So I have a whole

bunch of the information here and we don't have to spend a ton of time on this so I'll just hit some high points and we're going to send these slides out afterwards. They'll be posted to the Web site too so a reference point for people quick literature review. I also want to acknowledge my for rch partner Dr. Alexa who is my inner agency lead on enhancement project and she couldn't be here today. She helped me put together this literature review. Thawmpgz to Dr. Plask for the help. A lot of sources are from SAMSA because they have awe robust health equity office that collected this data. Some are a little older and some is because of census data but essentially the idea around health equity is this idea that everyone deserves access to quality healthcare. And that that includes behavioral healthcare. And advancing healthcare edge witness involves ensuring that everybody has an opportunity chk your that's trickier than physical health right some ways trickier in our world. We know it's trickier in terms of access, but it's also trickier in terms of how we define and promote mental and emotional wellness in our country and so part of that is because mental and emotional wellness are so rooted in social determinants of heamg. They have to do with things like our employment and housing and insurance status and context of the environment of the world. And that's why we also have folks on this call who do represent things like supportive housing and we want to be inclusive of the idea that mental and emotional wellness and disparities in that wellness are really rooted in opportunity and privileges and resources so it's complicated picture. One other really important point for this group being it's a state-based workgroup that we're talking about state agencies leading this effort and so I want us to balance in this conversation the idea of what can we do at the state level? What can we do at the locationality and community level? What can we do as collaboratives between the NCOs that are mapping the care I -- managing the care, providing the care, working to ensure access to care. How can we intersect and what different roles do we have to play in the goals and strategies that we put forward here? In my mind some of this is about at the state level and likality level identifying and understanding what needle we're trying to move. There's a lot of different needles to move and we're not going to effect change or feel that change or celebrate anything together if don't really pinpoint what is the thing that we want to focus on? What do we all want to agree around? We need to figure out what our baseline is and acknowledge the limbedtations of data but look at how we can operationalize what we're trying to change and then monitor trends in that overtime to affect the change and feel the difference. So there's that level that I think the state can play an important role in because we hold a lot of that data and we can share it and be transparent about what we have. We can also then think about what on the side of the community, lower level, the lockality, the ecosystem that our members exist in with the providers and advocates and everyone how can we focus those resources ashed r and enact certain interventions towards

changing the data. Changing the bigger picture? So we need to understand what inequities exist, pick our goal, and then operationalize it down. We can't just stick up here at the date we have to move downward and have partnership to make those things happen. This is just I reminder of how diverse our country has become. And how diverse we tun to grow to be. By 2044 estimate more than half of all Americans will be projected to belong to what SAMSA refers to as a minority group so anyone other than a nonhispanic white identifying group. So our country is moving rapidly towards being a more and more diverse place and understanding those disparities that exist and as they continue to evolve and change it's going to be really important. And also understanding that mental health and wellness across different communities and populations of people is very different. And what we do know from that high level national data is that people who identify with ethnic and racial minority groups often bear a disproportionately high burden of suffering related to mental disorders. That they bear that burden and historically rates of depression and anxiety have been lowered internalizing disorders have been lower in populations that identify as black or Hispanic Latin X than they are in white populations. They do tend to be those experiences of internalizing problems tend to be more persistent and there's a lot of data emerging in different spaces demonstrating that people who identify as longing to more and this one ethnic or racial group actually have kind of more intensive mental health challenges in some ways and we've seen that in COVID in some of the data as well that I'll talk about for the most recent mental health America report. That kind of integrated identity or experience of identifying across multiple groups there's many -- we could make I'm sure researchers have made many hypotheses we know that maybe creates a stressor or identity stressor that may result in challenges to mental wellness. And that group is followed by groups of people who identify as American Indian or last can native. By census definition. And then white and then people identifying as black. And individuals of American Indian or last can native identity report higher levels of PT scrks D and alcohol dependence than other em >> NICHOLE: And group members in the U.S. population. And historically people identifying as white Americans are more likely to die by suicide than people of other groups. This is probably not new information to most of you. On a high level just want to acknowledge the intersection between mental health problems and our criminal justice system. This is obviously an area of intense scrutiny and discussion right now. With everything that is happening when we talk about the crisis system, when we talk about the Marcus alert efforts here in Virginia. How these -- the system of healthcare and criminal justice are intersected and interwoven and how this creates criminalisation of people who are experiencing mental health challenges. And substance use problems. And so just acknowledging that you know mental health problems are common for people who are experiencing criminal justice involvement. And we also know

that there are disproportionate representation of racial and ethnic people identifying with racial and ethnic minority status within that criminal justice system. This more recent statistics thing about 50-75% of youth in the juvenile justice system meeting criteria for mental health disorders is relevant to the behavioral health initiative because twos of the systems are multi and functional family therapy which are targeted specifically and used in youth who have been involved in the juvenile justice system and used as preventative interventions to keep those kids from going into any type of institutionalised situation. Whether that be a juvenile just system testimony or residential care or hospitalization for mental health problems. We have chosen those in an effort to make a change there and you know kind of move those kids towards more appropriate mental health treatment. Rather than involvement in the juvenile justice system so that's a place I wanted to acknowledge. I'm going to move quickly through -- these are available. Mental health in America report for mental health America was just released for 2021. So I'm happy to provide the link to this in our follow-up or if you Google it it's hot off the presses. We've often cited this really helpful report as we talked about behavioral heathen advancement. Virginia in this report remains ranked at 41st in the nation in terms of mental health workforce supply but they also do rankings related to prevalence of mental health problems and access to mental health services which is obviously kind of interwoven with workforce issues. So I just wanted to acknowledge in this new report that Virginia remains in the struggle in terms of both adult and youth access to care. Go ahead did you have -- Julia did you have a question or comment. >> Julia: Briefly in your expert position could you sort of speak to why you believe Virginia's 41st? >> Alyssa: I can and I'd welcome it from any of my other astute peers here today. It's a really multi -- I think it's a multifactor y'all equation here in Virginia. The whole nation I should say first of all, has a major problem with mental health workforce. The mental health workforce is underpaid. And underreimbursed largely. Yes yes, you are hearing me say that. Yes. As a fellow mental health provider, yes, I believe that is true. We in Virginia we have some -- I think unique situations. One that's interesting to me Julia that I'll certaintier on is one thing we know from research I'm going to focus on adult psychiatrists or child psychiatrists for a moment because I'm a child psychologist and from the time I moved back to Virginia, I have struggled like probably everyone else on this call to find a reliable referral stream for child psychiatrist. The wait is always abysmally incredibly long. It's painful. So this is from the minute I moved back I was working in the community was really concerned about this. And what I've come to learn from research is that most people wherever they train, that's where they live. So for example I did my Ph.D. and I trained in child psychology here in Virginia. But there were very few residencey programs here where I could complete my training. I had to leave. There wasn't that many options for me so I left and then people tend to get a job

after residencey. Like either the place where you've worked or that same hospital system or communities where you get your job. So I left. I left and I went to Hawaii and I went to California. Which rank much higher in terms of workforce but maybe because they had a lot more training opportunities. So eventually I made my way back home here to Virginia but I think one problem has been our lack of training programs. Which kind of seems far off but for child there's data there's data showing that physicians they stay where they do residency. So we really -- one way that we can affect this is by having more support for training programs to keep people trained here and they stay here pause they're at the age where they're now potentially settling down in some way whenever that means for them and starting into their full career or their family life. And so we really want to that goes through different types of training but that data is specific to psychologists and psychiatrists we need to have training to keep people in the state. So I think that's part of it. I think there's you know a lot of other factors here. I don't know if anybody else would like to make comment on that. If not I'm going to make another controversial comment. Should I do it? I'm going to do it. There's also huge disparity, racial disparity in who is accepted to doctoral programs, who's accepted to graduate programs, who has the opportunity and privilege to attend those programs. And so we have disparities in our workforce and then in Virginia we have a situation where we actually have a very large what I would call in technical language a paraprofessional workforce so unlicensed workforce. Who were doing great work for our commonwealth but there's -- we have a lot of them and then we have far far fewer licensed mental health professionals than other states so these rankings that mental health America does are based on licensed professionals so they're very low. To me what that says is we need more opportunities for people who may not have had them to pursue their license sewer or graduate degree or hours in getting support in -- licensure or getting past barriers to work towards licensure and to receive graduate training. So these are big big issues. Margaret Steel is here I know and she's a workforce champion. Margaret I don't know if you want to add anything. >> Hi, no, I think when we look at actually I will say one thing, when you're looking at adult statistics here, the other portion is that I think it's important to note that Virginia based on our behavioral health needs assessment went into COVID-19 with data showing that we were already on the verge of a significant workforce crisis in behavioral health and substance services including psychiatric nursing and that the -- the data that we collected from our community service partners over the course of the pandemic has indicated that that has only worsened. The timeline and they are having very significant difficulty in engaging new workforce as well as the ability to maintain their existing workforce. Which puts services into a significantly high risk for individuals who are extremely in need of care following through some pretty significant -- following through pretty significant cracks so we recently

completed workforce survey at request of SUD mental health council and I'll digging through the data we collected and I think based on my preliminary look over it's going to show what we've been talking about here. >> This is Gail Taylor. >> Hey, Gail. Good, good to see you. >> Good to see you as well. Margaret referenced there are a lot of findings in there that lead to the fact that we really need to work on building our community-based infrastructure to make services more accessible for our citizens and it's across the continuum of services. So the report is on our Web site if you want to take a look at that, there are a lot of findings but it's going to take a concerted effort to make more investment in terms of investing in the community-based system. That way we can reduce the hospital census. We can create greater accessibility across the geographic Spectrum. Yeah. So those are key parts in terms of why we're still at the bottom so just wanted put that out there. >> Thank you for speaking up. >> One other question. Is there a connection between the health systems represented in Virginia and either their commitment to psychiatric resources or not? Or is it -- insurance and hospital systems has nothing to do with it. >> I think everything has everything to do with it and as someone who works for a health system and remains working for a health system in an ideal world one of the things we put forward for enviesing is this idea of didn't envisioning is greater integration of behavioral health services into primary care settings and also really strong data to show that people of color are more comfortable going into primary care settings for behavioral healthcare, there's less stigmatization. Whole person health you're there anyway for whatever you're there for and being able to kind of get access and see a provider right there is ideal. We know that but there are still very few fully integrated behavioral health practitioners into those settings and health systems. Like a sprinkling is my experience inexperience instead of a heavy dose in each kind of division and so there's a lot of -- some of that is about reimbursement. Some is about structures of how the systems are set up. But it is one thing that we do want to try to affect through the enhancement initiative down the line. >> Some of it has to do with significant internal bias in relationship to the population that's perceived as different with different needs. I once worked at a place that was housed and the clinic was housed inside the building with the health department and they wouldn't even allow our population to use the public restrooms. Because they didn't want our substance using individuals using the same restroom as the people who came from for the hath department care and that was not 10 years ago. That's pretty recent so I think that we just have a lot of tirnl bias and population -- internal and population bias that needs to be addressed before we can move toward a collaborative system that is desperately needed. You know I mean it when I turn the camera on because -- >> I know you mean it and I agree with you March Internet. There's -- that could be -- maybe it will be a whole conversation of this group is about that issue of integrated whole person health and how we

can use that as a -- one of the pieces to move forward. So I'm mindful of our time. I'm going to move forward through some of these statistics so that we can reach some of our kind of specific goals today. But essentially, we do see racial disparities across prevalence of mental health problems and in the mental health America report they did some really interesting stuff this year. They have -- it's a fascinating report. I recommend all of you go and read it. You will be glued to it. But it is the first time that mental health America has asked about racism in questions about -- they asked questions about what is Trish continuing to your mental health this year? And they added racism this year and 7.65% of the respondents said that -- that directly that racism was involved in the status of their mental health. There's a lot of fancy numbers on here. But essentially if I boiled it down, what the report said is that number one, they've had more screenings than ever before during this year of COVID in terms of anxiety and depression on their site and mental health America site. And what they saw is that people who identified on the survey as being black Americans have -- their rise in anxiety over the course of the year and their rise in both moderate to severe anxiety and in depression increased over the course of the year including Native Americans and American Indian identifying respondents. And then the sow side ideation rates actually grew across all populations suicide. But the greatest growth was in the Asian Pacific Islander population of respondents. Who this was really stood out. Those folks identifying with that population and noting that they had suicidal ideation every day went from 36 to 43% of respondents. And in the population of black respond Ents it went from 29 to 38% over the course of the year. That is a significant proportion of respondents. You're talking about a biased sample you're going in to do a screening about your mental health because you're experiencing something. You know? You're looking for something. To do the screening but to have those rates grow that much over the course of a year for those that are actually think about suicide is pretty profound. So you know these will obviously be subject of a lot of conversation here around what causes some of the issues of access and we know of course and this conversation has already acknowledged there's a lack of cultural understanding by healthcare providers. As Margaret noted not just about kind of the expression of mental health and mental wellness or mental health problems in different cultures or racial ethnic groups. Also stigma just about mental health in general. You know, stigma about mental health disorders, misunderstanding. And there are significant language differences. And also language in the way that we describe our mental health and mental wellness. And that can contribute. I've certainly experienced that living in places where we had many more languages than we tend to see here in Richmond in Los Angeles count are he in our waiting rooms we had 10 different languages of consent on the wall and we did a significant amount of training for staff around just the different words that people use to describe their experience of

emotion. You know? That there's a lot of different ways to do that. And it can impact on -- and intersent with implicit bias on how to interpret those and what to diagnose. So there's -- and there are different -- there were a lot of study and writing around cultural presentation of what we call symptoms but just as people's emotional experiences. There's different ways of describing and experiencing that and being sensitive to and understanding that is important in the diagnostic treatment and development process. So we also know basically that there are significant disparities in who has access to and participates in mental health services in our country. These are basic statistics on that. You'll note I try to be mindful in the way I are you talk about engagement in services. I like to use the word "participation" to signify choice that someone is participating in that experience with a provider. There's been a lot of other terms that have been used. I don't like the terms if you answer compliance to treatment, I think participation is a more humanistic way to approach that idea. But engagement is also often frequently used like how are people engaging with a system, engaging with provider. So I try to use the word engagement and participation throughout this but, if folks have other ideas about ways to conceptualize that, I'm absolutely open to that. Just to note that again this issue of people who identify as multiracial it says receive I don't like that word but participate in outpatient and more likely to use prescription psychiatric medication than other racial groups. In patient services are more frequently uniteised or participated in or perhaps in the case of a TDO we could say not really participated in by black adults and those people reporting two or more races and Asian individuals, API individuals are less likely to use mental health services than any other race or ethnic group. And there's just general intersectional gender trends where women are more likely to utilize services and participate in them than men. So when we start to think about together, how we can affect change in this area, in some preliminary conversations we've had across agencies we've really thought about barriers to care and access to care as a place we could really find momentum because we're talking about new services. Now ak access he to these services they don't really scwift in Medicaid. That seemed like an obvious place to start brainstorming together is around can we about disparities in access, how can we take action steps together to address equity and access from the outset for these services that we're bringing into the benefit? Because we know there are going to be disparities across all the services in the Medicaid benefit most likely. Some kind of disparity or another. That national data I necessity we say we have our Virginia way and our way is special but we're going to reflect those disparities. We're probably going to have our own character to them but we want to characterize that and we want to try to focus again on enhanced services and type of progress we're making right now. And thinking about services we're bringing in. What kind of barriers could play in and how might we take action steps together to address those barriers for these particular

services as we begin to implement them together. I say that together because this is a coordinated effort from medicate as payer from DBHDS as licenser. From even DHP as our partners in their individual licensing process. Providers who provide services, MCOs who help to manage the services. Advocates who help make members asquare of services and give feedback, numbers themselves is a whole coordinated process. How can we each from our own seat at the table try to affect these barriers to care? And that's where I'd like to try to direct the conversation for this last segment. Of the meeting. We can come back to the slide. Our thinking is that if -- what we can offer from the state level is to try to develop some baseline data as the services launch and going into the services about expectations and kind of what we're looking at, desaggregating that data across whatever way the stakeholders are interested in looking at it. Geographically, through gender, through race and identity. Data where we have it, that data as probably everyone on this call acknowledges is always kind of messy and self-identified. And we often have missing data but what can we use within the data to develop baselines and then monitor that and then see where we can make some kind of very specific action steps and how we can affect and move that needle. Open of osar to other data methodologies, looking at data at different levels or from different sources to try to answer questions and be curious about what's happening. And we also had good discussion about potential action that really kind of grassroots and in local partnership kind of like what BDH has been doing in the community conversation that's they've been having about COVID, current fierm yod are there things we can do in locationalities and providers and MCOs who manage to have conversations to help the community be more aware of the new services to understand what they are so they feel they have choice and voice in participating are there ways to circulate things on social media or throughout communities kind of informational things to deal with stigma and participation in services or just information with how to access services oar what providers are available. Those were ideas coming into starting this group. I just said those because I didn't have the right slide up. The services for those who may be part of that conversation are that on July 1st and DBDHS will be launching partial hospitalization programs and intensive out patient programs for mental health. Many of you are aware we have these services in our arts benefit for substance use disorder but we don't have them for mental health so these are for adults and children for mental health then we will be enhancing what's known as intensive community treatment service and Medicaid to turn it into the full fidelity assertive community treatment that is offered across the state mostly by CSPs but some private providers who provide this kind of hospital without wheels approach to a multidisciplinary team for folks who are living with serious mental illness. So these three services are our big concern for July 1st. And then on December 1st we'll be launching a full overhaul of our comprehensive crisis system. In partnership

with DBHDS, the 988 legislation Marcus alert trying it all together to bring mobile crisis including peer rates for mobile crisis. Community-based stabilization residential crisis in 23 hour observation. And then as I mentioned earlier in this conversation, multi systemic therapy and functional family therapy will also come on line at that time in December. So these are the services that we want to focus on in terms of thinking about equity. And how we can drive equity through action together. I'm going to go back to some of these preliminary ideas. I would welcome any conversation or discussion or reflection on what you think about these as a way to move forward. Does this seem reasonable? Does this seem like something that would excite you to work together on? What do you think about this scope of working on access to care for services around equity? Starting point. . >> This is Julia again. >> Go ahead, Julia. >> Okay Julia: I apologize. I'm curious about the date. Is that relevant as we'll be nominating or excuse me electing a new Governor right before then? Or is it just December 1st for no reason? The reason is tied to the budget for biennium for dates that we submitted to -- it was initiative actually had totally different dates prior to the pandemic. We would already be way into our first phase of implementation but the money was unallotted during the early part of the pandemic so we're reallotted or special session we had to push back the dates that's also lined up on purpose. December 1st with the tbrur that's being set up for regional call centers through DBDHS because we want call centers to operationalize the mobile crisis throughout the state across CSBs and private providers. That's why December 1st. >> Mary, did you have something too? >> We are diving into and collecting in our data for social services and I'm thinking that part of the brainstorming is pooling what data do you currently have at your specific agency or department? Centers around disproportionality and racial equity as children entering foster care as well as child abuse and neglect. We're having a lot of good conversations about that currently that we would -- that I think we'd be more than willing to bring to the table here. >> This is Jane from RACSB and I appreciate the access certainly. We're having conversations or I'm having thoughts and I've said them out loud until now. Of hiring diversity person here and I want it to be meaningful and I want it to address access to care but it seemed like such a big bite to me. So to focus on the BRAVO piece for our five localities is a -- makes a lot of sense as first steps. Of course, there's so much you could do just means nothing and has a word to it because it's what everybody is talking about you want it to be meaningful and I think that's a great way to think about it with these BRAVO services because it's a good place to start and go from there. Sorry, I'm the W-- excuse me, the YR W83444 -- this is Zandra over at the Office of Children services. >> Hi, everybody. >> Hi, I'm so glad to see you and glad I overaim whatever technical difficulties I was having. >> So glad you were here, I was just thinking about you. I'm glad you're here. In addition to other folks who are around as collective table impact and drive the

services we hope to provide and support here at OCS. So we too are engaging in some of the same activities as far as taking the first or second look at data and utilisation and regarding utilisation. And raising ethnicity. So I say bravo and I look forward to what we can all learn and hopefully make recommendations for. Services and collaboration and access for all. So just wanted to say that. >> Thank you. >> Hi, Mary Alyssa: And I think too for those who aren't -- you know, at the agency level and Vice President been part of these conversations the child serving agencies in particular have been talking a lot about the inintersection of SST and FST in the family services act and how they're going to be different payers for these services. DSS is going to be an available payer 34 he, Medicaid is going to be a payer, OCS already pays for these services for kids involved in the DJJ system so us being able to compare our kids that we're serving and who abeing accessing them are there disparities in how kids goat access by which funder how can we make these ak accessible as possible will be really important and looking into DJJ too that's preliminary stuff we can look at. Some we don't have that baseline ourselves. And see how we can build uch early gains they had. >> Julia: I'm sorry to ask so many questions but I was tapped for this and I'm not an agency person. >> We love having you here, we welcome all your questions and comments. >> Julia: I appreciate that. What does BRAVO stand for? Alyssa: So I'll tell the story real quick. Stands stands for behavioral health redesign for access values and outcomes. Health redesign for access value and outcomes. >> And the root of the term project BRAVO is that this initiative was originally called behavioral health redesign in the Governor's budget and it was also named enhancement Dr. Haze mitt on who tragically died in 2018 his call sign as a pilot was bravo so we wanted to dedicate the project to him since he was one of our biggest supporters and nush yatetors of the project. >> That's really deep. Thank you. Other thoughts about this idea of access as a preliminary variable of really you know moving forward? . >> What is the timeline you hope to accomplish? I mean, you mentioned those dates, but how -- >> Alyssa: That's a good question. My thinking is that I want this to be helpful to the larger cause but I also want it to be not whoaferlth and particularly I know that our team -- overwhelming and I know our team has many, many different work -- versus online so my thinking was to meet bimonthly so every other month for the workgroup and have kind of work plans that folks are taking back and working on in the off month and then coming back to the workgroup every other month. That's what I was going to propose. I'm open to other options. I'm assuming too that if this group holds together and maintain and find -- folks find it to be reinforcing and sustaining that we could break off into smaller groups who could meet op their own schedule. They might be community specific or they might be regionally specific and could focus on leveraging access you know in certain kind of subgoals. For example when we launch MSTFT, it might be a smaller group of folks who are really wanting to

work specifically on that goal. So -- but I think for the big group meeting every other month would allow us to set goals and one of my thoughts was we're meeting now to engage and see each other. If we met in two months that would put us in gracious, June. And at that time at the state level we could commit to coming back with some preliminary state based baseline data where we have it to present. Maybe that would be you know for example we have arts data for PHPIOP, maybe we could talk about what it looked like in that benefit. We do have data on who is participating in ICT before it is converting over to ACT so we can talk about that data and kind of look at some known information on who has access to and is participating in these services and that can get us a jump off maybe or setting preliminary goals for once they go live in implementation. Mary? . >> Mary: Can I add a ground rule back to the beginning slide? Just be mindful of our use of acronyms, am I world uses different acronyms than your world uses and I goat so confused. The first time you say it if you would say what if is and then say the acronym. >> Here here. >> I happily will adhere to that rule and agree and I now -- I see Ruth putting her thumb up it's so hard and I feel terrible I'm acculturated to speaking in alphabet soups. Oops. Oops, I'll do better. Start with BRAVO is an acronym. >> It is. >> Okay. So I'm mindful of the time. It's 2:16. Any -- you know, any kind of contrary comments any thoughts of access doesn't seem like the right focus here or I'm not really feeling this? Anybody have any of those kind of thoughts stirring within them? Mary? >> I was wondering do you feel that you have the right people here at the table? And are we missing people? >> I think that's a great question. >> Mary, thanks for the question. I was going to ask -- I was thinking about when you break folks up into groups like would it be folks who were state people or -- I'm from child welfare and therapeutic to the ter care agency. So you know do we mix ourselves up or do we work around those things that we know specifically? So . >> Alyssa: That's a very good point. . >> Getting our full roster we had a lot of people nominated but not as many who registered and -- this is not -- it's not registration or nomination event because it's closed to people. It's really just so we could organize who is participating. So, if you have -- if you've been here today and have ideas about things you think you would want to bring into this work please email us and enhance and let us know and we'll include them. We'll go over the roster that will be another action item for us at DMAS and DBHCS and we'll look ago the roster and figure out whether we think this is a robust representation of the parties we need or whether we need to come back to you and email and ask if we can set up some ways to nominate additional members or people that we know are missing that we want to ask. I think that's a really good point and a really good starting point. . >> And do you want that membership to be fluid? Would we be 6 months into the work and new parties join or do we keep it relatively familiar because I've been in other workgroups where that can be very disruptive and also good. There's pros and

cons to the -- >> One thing I've liked about the big enhancement process is we did have a core stakeholder workgroup of the original -- my team -- I wish I could see all their faces I can see Laura so she might smile at me. I call it the Orc G workgroup because they're the originals. We were -- OG. We were all together from the beginning and we got literally hundreds more people into the service specific groups and we always came back and reported out to what I've always called the OG group. So I like the idea of having this established group and then we could have offshoots focused on certain specific goals or even certain specific communities. And then they can report back out but they could draw fore folks from their subject matter expertise or their regional area or whatever. I think kind of the way we've done enhancements so far which I think has worked pretty well. . >> Alyssa, this is Zandra. Is having participated in part of that I was going to say that I think the model you all used before was a great one where you had a core group but added as needed and when there was more and when there was relevant and additional information to share and get feedback on and proceed with some action steps so I think that's a great recommendation. >> Thanks, spoken as one of the OGs. Along with many others here. Gail. It's fun to see the people returning back for this group who we've had in other groups. . >> It's a pleasure. I'm going to move our slides along here. Just for folks who are new to that implementation I just mentioned this large group is the OG group. These were all our other groups taking different forms this is original conceptualisation these are folks we can pull from. They are providers who were interested or doing the current services and we plan on hearing those groups who met really together to do our rate study and to look at our medical necessity criteria. These factors we turn them into learning collaborative groups to continue to meet to really learn from each other how the implementation moves forth and makes sure it's smooth and when ineftdble bumps arise we have blej solving together. They would be great to draw from. If we get into kind of service specific equity action items. We have internal quality group. But that would be a good group -- that group will be helping this group because that internal group at least involves all our data people. So they will be helping us to pull and integrate data. And this group has not started. We have not launched an EBP workgroup and that's in part -- I won't get into that alternative thing happening happening. Workforce group is DBDHS effort when there's more funding for that because not all the workforce funding was realossed. This is our group here and MCO resolutions panel as well. These will be on the slides if it you want to refer back to it. My thinking is that -- my ask of you in this intervening period before you schedule the next meeting in two months, would be for you all to come back to marinate a bit and we'll prompt this. We'll send it in a prompt so that you can remember. I know you go to so many meetings and so many action items but to bring ideas of variables of interest related to access or maybe some that you already have studied or

looked at or what worries you around disparities around access. Disparities and access, I observe get really helpful after meetings like this people will send me writings or things they want me to consider so we totally welcome those if any of you have writings they could be empirical or not about this topic we would love to create a repository of those for the group. To national Nate anyone like was mentioned who isn't here, community partners you think would be helpful be thinking about those. And also consider for yourself like as we do break into subgroups, certain service area or geographic region. Would you consider partnering with us to do that. We will go ahead to set up the next meeting and we'll do a data drill down to see the data that we have existing on baseline for some of these services around disparities and do what we can to visualize that for you. And we'll try to send that out before the meeting so that you can digest it before we join together and we can have a discussion about it and how we can turn some preliminary baseline data observations into things to make into boys and to evolve over time and to monitor. Does that sound like a reasonable action plan for this group? Quo anyone like to add anything additional? . >> Weird but for pondering producing materials in bilingual form across the language Spectrum? >> Yes, absolutely, we would love to work on that. And we have new resources at DMAS over the course of this year Julia that we already had in the past and we are really excited we'd love to involve them. They've been really helpful to us during COVID and -- they could become more involved in this process and partner with us. I think that will be a really important piece. We are going to work on putting these materials up on to our Web site. DMAS is getting a new Web site as of April Laura is it 24th? So we can't post it until the 24th because we have to wait for the new Web site to go live but the new Web site is good news and as always as we've been doing over the course of COVID we post all our public meetings, the recordings of them, slides, we put everything on to the Web site so, if folks weren't able to come or you want to review them or review materials they're available there for posterity. And then it makes them truly public. So we will work to post the things we will send out invitation for the next meeting and we will do the registration again just because it allows us then to understand who's coming. Registration is really like an RSVP through WebEx so we know who's coming. We are so grateful for you being here for your patience with us and for your commitment to equity and I hope that everyone is doing well in this very complicated and weird time that we're sharing together and I'm grateful that we're still able to gather in this way and keep moving forward from all of our different homes and places where we're out in the community. So thanks so much for everything and I look forward to learning alongside you for this work. We will see you in June. >> Thank you. >> Thank you. >> Thank you. >> Good seeing everybody. Laura I'm not going to end the meeting yet because I didn't see any of the chat so I'm going to read the chat before I close the meeting. >>