A COVID-19 SPECIAL REPORT

Lessons from COVID-19: The Future of Behavioral Health for D.C. Children and Families

June 26, 2023 A roundtable discussion on findings from the report from the Office of the D.C. Auditor

Office of the District of Columbia Auditor

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This report is a transcript from the April 20, 2023, roundtable discussion held at the John A. Wilson Building on the ODCA report,
COVID-19 & Behavioral Health in the District of Columbia

INTRODUCTIONS:

Mr. Christopher Murphy, *Georgetown University*

The Hon. Kathy Patterson, *Office of the D.C. Auditor*

PANELISTS:

The Hon. Christina Henderson, *Councilmember At-Large, Council of the District of Columbia*

Dr. Barbara Bazron, *Director, D.C. Department of Behavioral Health*

Dr. Ellie Graeden, *Research Professor, Georgetown University Center for Global Health Science and Security*

Dr. Lee Beers, *Medical Director for Community Health and Advocacy, Children's National Hospital*

MODERATOR:

Nathan Baca, *Investigative Journalist, WUSA9-TV*

MR. MURPHY: Good morning. I am Chris Murphy, and I'm Vice President for Government Relations & Community Engagement at Georgetown University. We have partnered with the Council and the Executive Branch to host events in the Wilson Building for many years, and we're glad to be back after an absence! In just a minute, you're going to hear from our Auditor, but I'm grateful for the partnership with the Office of D.C. Auditor who made the report possible that we are releasing today. I'd also like to thank the Council of the District of Columbia for hosting us today.

MR. MURPHY

Next, you'll be hearing from Dr. Ellie Graeden from Georgetown Center for Global Health Science and Security, which the D.C. Auditor commissioned to write the report. Dr. Graeden is an internationally recognized researcher focusing on data to drive local, state, national, and international decisions that are made in the public health response to emergencies, like COVID-19. She and her team were uniquely qualified to analyze the data that went in today's report and serve as the foundations for its recommendations.

Dr. Graeden will present a summary of the report and then join an expert panel that represents diverse views and different institutional perspectives on how D.C. should respond to the report's findings and recommendations. And we also have WUSA9 investigative reporter Nathan Baca, who is here to moderate what we know will be a lively conversation, and we will be inviting you to ask questions and comments and participate in that conversation.

So thank you in advance to all of our great panelists. Special appreciation to Councilmember Christina Henderson, who has made time during budget season to be here, and if you know the Wilson Building, you know how crazy this time of year is, so we're particularly appreciative of her joining us.

And now, it's my privilege to introduce our partner and leader of the office of the D.C. Auditor, Kathy Patterson. Kathy is no stranger to any of us. As you-all undoubtedly know, she has served ably as the D.C. Auditor to—since 2014, and earlier this year—

AUDITOR PATTERSON: Re-upped.

MR. MURPHY: Re-upped for another six years of good work. As you know, the Auditor leads a legislative team that also works with outside partners like Georgetown Center for Global Health Science and Security and many others to produce reports evaluating the D.C. government policies and practices, and one of which we're going to focus on today.

AUDITOR PATTERSON

AUDITOR PATTERSON: Thank you very much. And thank you all for being here.

Early in the pandemic, I put a call in to Dr. Rebecca Katz at the Georgetown Center for Global Health Science and Security and had met her through the Commission on Homeland Security that she served on. I said our office is really trying to figure out what we can and should do that would be helpful in this global pandemic. At that point she was preoccupied with advising candidate Biden on everything COVID and referred me to a colleague, Dr. Ellie Graeden. Dr. Graeden founded and led Talus Analytics, a data analytics firm that was

using data on the local, state, national, and international level to better inform policymakers so they would have information across the subject areas, and particularly within the health arena. Dr. Graeden and her team produced several reports on mitigation policy during the pandemic including a fascinating analysis on demographics and mobility, and another one looking at education policies.

About a year ago, we started talking about whether we are in a mental health, behavioral health pandemic given the severe impacts on so many of us. We asked how would we know, and what would we measure, and what metrics are there, and what data is there? And that's how this report began and how we came to be working with this very fine data scientist. Now we're going to hear from Dr. Graeden to present the report.

DR. GRAEDEN: Thank you all for coming. It's lovely to actually be doing this sort of event in person again. I'm going to tell the story, and then we can dig into the details and have a discussion with the rest of the panelists as well.

DR. GRAEDEN

So as Kathy described, we started this conversation about a year ago. I, like so many of us, have been reading the articles in The New York Times and The Washington Post about how many people were really struggling with mental and behavioral health issues during the pandemic, but also as we were all trying to figure out, do I still have to wear a mask? How long do I wear a mask? How close can I stand next to somebody? Should I be making my children wear masks? We had all of these issues, trying to figure out how to maintain childcare and deal with stresses around aging or ailing parents. Layers upon layers of stress that we were all hearing about.

What we didn't have was a lot of good data, right? Every time I looked at reports and read the articles, they were filled with touching anecdotes, but there wasn't a whole lot behind it. And I'm a data person. I have a Ph.D. in biology. I've been doing a lot of work as Kathy was describing, with Rebecca Katz on the international stage, working with the Biological Weapons Convention and the WHO [World Health Organization] and working with CDC [Centers for Disease Control], looking at hospital data integration systems and how you move samples across an international border when it's a restricted sample? If you're trying to move Ebola samples, for example.

So, there's a broad range of topics, and sure we have the story, but where are the numbers? How do we understand what we're seeing in quantitative terms? And the reason I care about the quantitative terms is because it's a good way to measure if what we're doing in the qualitative space, in the human space, is having an impact. We know this from the business world: we know that if you want to talk about whether your business is working, you measure it. You measure how many people you're interacting with, how much uptake you're getting, what the financial drains are. We need those sorts of measurements on the public policy side of things, but they're often much harder to get ahold of. It's harder to measure the impact of policies.

So that's the space that I sit in, and what we had been doing during COVID was evaluating the impact of the different types of policies that we put in place and asking what works, where, and for whom, and in what context.

And so, we took that same thinking and applied it to mental and behavioral health. I'm going to say upfront, many, many thanks to Dr. Bazron, who educated me on the behavioral health side. It is not my area of expertise, so I will absolutely be deferring to the other panelists who have more expertise in the specific topic area. But the first question I asked was, how do you define mental health? How do you define it? And not in a sort of intuitive 'what does it feel like' sense, but how do we measure it, right? What is the actual clinical definition? But hey, wait a minute. I'm not hearing anecdotes about more schizophrenia diagnoses. What we're hearing about are levels of community stress that are rising. We're hearing about loneliness and depression. We're hearing about isolation. Do we have good measures for that? What do we call it? And it turns out that behavioral health is this much bigger, overarching category that includes substance use disorders, things like the opioid crisis, but also includes any sort of community level stressors that we're seeing.

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> **DR. ELLIE GRAEDEN**

Places like CDC are doing work in this area. The CDC's BRFSS [Behavioral Risk Factor Surveillance System] is quite the mouthful. It's looking at behavioral health impacts and surveying people across the United States to ask them what their experiences are and how they understand their own mental and behavioral health. So, we have some data coming in from those groups. But there's this broader question of how we even look at this.

So, as we started to dig in, and here I'm going to do the thing that scientists always do, and I apologize, but I'm going to lead with our caveats. So, what do we not know? The only data we had rapid and ready access to was Medicaid data. These are the data that are housed and owned by the District, and that we could actually get into.

The data group here within the Department of Behavioral Health is terrific. A huge, huge shout out to them. They were incredibly helpful in figuring out even what data were available. As a reminder, any of the data in these systems are, by nature, health data. That means they're constrained by HIPAA [Health Insurance Portability and Accountability Act] compliance. That means these are not public data. And if we want to make them public, there's a whole series of regulations around how you do that. So the fact that they were willing to figure out how to make that accessible to us was a huge lift and I want to highlight the value of what they are doing.

When we first went into this, our hope was to compare COVID-19 with prior events, say 9-11 or the sniper crisis that we had. So, the question was, can we get data over the last 20 years? And the short answer is no. That's partly because it turns out we upgraded our data systems. That's actually a good message and a wonderful thing. It also means that the data stored and collected in 2001 are in fact not in a format that you can readily pull them now. Also, there are constraints like billing codes. It turns out billing codes changed between 2016 and 2017, we went from ICD-9 to ICD-10, and all of a sudden you actually can't do comparative analysis across those codes. Also, we have smart, well-intentioned retention goals about how long we hold

onto sensitive data. So after about five years, you put them in deep storage. So again, what you're going to hear today are the results from analysis from 2017 through this summer, give or take. That's a good solid five-year chunk, but that's why we're not looking beyond that, and why we weren't able to make great comparison with prior events. Thankfully, though, when the pandemic started in March 2020, we had some good baseline information about what normal, or at least pre-pandemic, looked like. So, we are definitely comparing against that.

So, what did we find? First off, we talked to over 20 different groups of folks across the District to ask what data we should be looking at. We never go in assuming that we're the experts or that we're going to know where to go, and we needed to learn the lay of the land and figure out what data we should be looking at, how to ask these questions. We looked at an inventory of over 100 different data sets. Some of this is across D.C. some of the data are from CDC, trying to get baseline data from across the United States to see how D.C. is different. We tried to make sure that we were understanding the full landscape and that we were capturing as much as we possibly could.

What you see in the results are a curation from across those data sets. We're always looking for contextual measures, trying to make sure that we're cross-referencing, and that what we're seeing accurately represents the world. And so especially when we saw answers that didn't quite line up, we saw things that didn't make a whole lot of sense in context, we could dig a little deeper. That's what you're looking at here.

Some key take-home messages: one, we did see an uptick in behavioral health needs. Again, a few caveats here, right? There's a difference between a need and someone seeking care. We only see care-seeking behavior in the data. Until you interact with the healthcare system, we don't see you. So just because we're not seeing it in the data doesn't mean it wasn't happening in people's experience; it just means we can't describe it. So, this is where I as a data person start jumping up and down and saying, we need to find better ways of assessing how people are doing on these levels. That said, what we're able to look at are Medicaid data; we're looking at care-seeking behavior.

The other caveat is we wanted to know both sides of the supply-demand curve. We would've loved to have understood, 'do people have doctors to get care from?' 'Do they know where to go?' 'Can they get that care?' Turns out there's no registry. You can ask, for example, across the District, how many people have licenses in the District. You have no idea how many care hours a week they're providing. None of us have any idea what the cumulative waiting list time is or what the attrition is from that waiting list. How many people wait for two months and then just drop their name off because they've given up? We don't have that information.

What we did know, we saw about a 15% uptick in the DBH care provided at the start of the pandemic. Actually, in January 2020, there were some new policies put in place that expanded Medicaid access, so this was all happening together. We can't tease out all of the drivers here, but we can say what we saw. We see that uptick. What we also then saw was that as soon as the pandemic started, thankfully, there were a whole lot of new policies that said, hey, wait a minute. If people can't get physically into their offices, into healthcare offices, we better make telehealth available. And it works. I think the single biggest take home message from the entire report was, oh boy, does telehealth work! And when we all of a sudden made that care available, you saw a dramatic uptick in people seeking that care, using that care. What was interesting is that you see a decrease in the in-person. No surprise. This was March 2020, none of us were going into our offices at the

time. But you actually don't see a significant change back. People continue to use that telehealth service. And that's a really powerful statement. What we're starting to see across the whole United States is cities and states starting to pull back on things like telehealth care. You see hospital systems deciding that they're going to pull back those services now that people ostensibly can go in person. So, my single biggest take home message from all of our work here was, oh boy, let's make sure that we're really investing in telehealth and maintaining those services.

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That's paired with a very significant increase to suicide help line calls—over a 200% increase. Interestingly, there is at least one lens on those that is that it's just another form of telehealth. It's a freely accessible source by which somebody can pick up the phone, call, and expect to talk to a behavioral health professional, and get that support. And that's particularly important when people are experiencing isolation and when they're experiencing loneliness? These are all contributors to mental health, and these are really important resources.

We did see an uptick also in just total DBH load. Interestingly, we did not see that in children. We actually had very, very little data that we were able to get for kids in general. I hope Dr. Beers is going to be able to speak more to this.

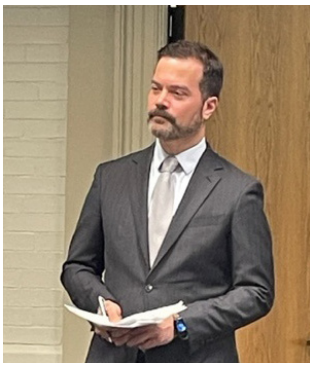
What we weren't able to do, especially in the short window that we were working on this was to get data from private care providers, so we weren't able to get the children's data, or a lot of it. And we're excited to be able to start expanding this. A big message here is that there is a relatively new private-public working group that's already established by DBH, and this is an opportunity to get those data moving.

Another message is a need for a consistent documented definition of behavioral health, how we define it, and what those metrics are. We need to make sure that something as simple as units are consistent. If we're going to talk about kids, well, do we bucket in the under-five, five to 12, 12 to 18? Or 12 and under, 12 to 18? Or is it just 18 and under? And when we start talking about how we roll it up by geography, is it by ward? Is it by ZIP code? These are the kinds of things that sound wonky, but it turns out they're the primary differentiator for whether you can cross reference the data and actually merge them.

So hopefully we can take all of those messages and be able to move forward and we have some concrete recommendations for how we start to collect those data, define them, and where we can go next. But I'm really excited to share the stage with the rest of the panelists and learn more from them as well.

MR. BACA: What Dr. Graeden was talking about regarding stories and putting quantifiable data to the stories, that is exactly what the press corps has been seeing, what first responders have been seeing, what the entire social services community in D.C. have been seeing throughout the pandemic whether it's the story of a family who has been affected by a loss of an opioid overdose, a person who has been the victim of domestic violence and going to D.C. SAFE and needing help in the midst of the isolation of the pandemic,

whether it's a new mother seeking telehealth through postpartum depression, a person who had been arrested during the Black Lives Matter protest and feels a sense of fear and loss because of what happened to them on Swan Street. Those are the stories that have hit our community, and now to be able to have two powerhouses of research, the D.C. Auditor's office and Georgetown University, come together to find answers is not only what, you know, intrigued me , but I feel that this report finally gives some sense to some of the pushing back the mists of what we don't know.



MR. BACA

It is my honor to be able to present our panel here. Of course we have Dr. Graeden, who has been a research professor at Georgetown University. Dr. Beers is the Medical Director for Behavioral Health Initiatives for the Pediatric Health Network here in Washington, D.C. She also oversees the Child Health Advocacy Institute's Community Mental Health Corps, and she is the 2021 President of the American Academy of Pediatrics. So, of course, her expertise in pediatrics will be much welcome here, especially considering that the report was talking about quite a bit of what we don't know about Pediatric Behavioral Health.

Also joining us is Councilmember Christina Henderson. She is a chairperson of the Committee on Health, And as we know that the entire Council is quite busy on the budget, we thank her very much for taking the time to join the panel.

And then last but not least, is Dr. Barbara Bazron. She's the Director of Department of Behavioral Health appointed by Mayor Muriel Bowser. And also has experience as a clinician family therapist.

Dr. Beers, reading this report, what are some of the top impacts you've seen on children and health throughout COVID-19?

DR. BEERS: Well, first of all, thank you everyone for the opportunity to be here today to talk about this issue.

DR. BEERS

I appreciate Dr. Graeden's remarks and this excellent report and I think that one thing that is important for us to frame this discussion about, when we think about the impacts of the past three years on children and their mental health, is that this has been a crisis—this was a preexisting crisis to COVID-19. And I think that the impacts of the pandemic have absolutely amplified the mental and behavioral health concerns that children have, and they've amplified the systems issues.

You know, as I took on my role with the American Academy of Pediatrics in January of 2020, things changed dramatically for me in the course of a couple of months. But we were preparing to head into our leadership meeting in early March and had gone through quite long process to identify what our top priority needed to be in the years moving forward. And we were prepared. We never actually got to vote because we had to cancel the meeting, but I think that's how it would've gone, to identify mental health and delivery of mental health in our systems as our highest priority.

So I think that speaks to the fact that this has been a longstanding issue. I think the data issues are also longstanding. You know, it's long been of frustration of pediatrics that we don't have the child health data that we need. And particularly for this issue, much of that data is very decentralized. And we have to think about the continuum of mental healthcare from health promotion all the way to treatment and recovery, but for children in particular, so much of that care is seen in the early side of that continuum, so the health promotion, the prevention, the early identification, and that's the stuff that doesn't necessarily show up in the Medicaid data sets, right? And I have a lot of thoughts about that too, but we'll get to that one.

MR. BACA: Well, and on that subject regarding data integration, what can we do moving forward in integrating that data? And also just what did your report really show when it comes to children's impact— the impact on children during the COVID-19 on behavioral health?

DR. GRAEDEN: As we look at these data, having a really clear definition of what does and does not constitute behavioral health; how do we define behavioral health versus mental health; having a standard set of units, this is the kind of thing we work with the Academy of Pediatrics to define. If you're going to report the data, let's use these age buckets. Let's use these gender markers or characteristics. And how are we going to roll this up? So that we can do longitudinal analysis and cross-sector analysis, for example. So, I think it is just very simply standardizing a data dictionary. It turns out defining terms in English matters just as much as defining terms in the data. I think just getting really tight on that and then publishing it broadly and doing some work toward standardizing would go a long way.

The other piece that I think is worth pulling forward here that I didn't mention earlier—we talked to a lot of folks in the schools. We know that the schools are the first point of contact for a lot of kids who are entering mental or behavioral health services or expressing need. The District has put in some wonderful programs to get providers into schools. Well, we don't have any data on them yet: how busy are those people? And are they busy because they're not getting well marketed or advertised across the school district? Do the kids know they're there? And do the kids feel comfortable going to them? And do they have anywhere to refer the kids to once they identify a problem or an issue? So we're just at that point where we can start to collect some of those data. But I think when we start thinking about kids especially, we need to be thinking about data collection outside of just the healthcare provider community. We need to catch them in a preclinical setting and that preclinical setting is almost always going to be a school. So it's starting to think about a broader range of potential data sources, but also a broader range of ways we can support people of any age.

> ***"We need to be thinking about data collection outside of just the healthcare provider community."***
>
> **DR. ELLIE GRAEDEN**

MR. BACA: Dr. Bazron, when you hear Dr. Graeden talk about the importance of school being a first point of contact, what are the priorities to be able to improve here?

DR. BAZRON: I did want to also address the issue that was raised about behavioral health versus mental health. First of all, behavioral health is mental health and substance use disorders. And we need to think about that as a part of whole health. And we really do need to address the fact that as a result of COVID, we found that a broader group of members within our community all needed some supports. They didn't rise to

the level of the diagnostic criteria for mental health or substance use disorders; however, individuals who are experiencing stress, the impact of trauma, the impact of isolation. And you might consider them kind of the worried well, the mild and moderately involved. And I think it's important for us to have that as a part of our framework.

DR. BAZRON

Within the school system, Mayor Bowser has provided funding, along with our Council, to support having a licensed mental health clinician, in every public and public charter school. And the goal there is to look at the public health model and to provide prevention, intervention, treatment and recovery services for kids, and where they are for most of the day, which is in school. The clinicians actually go into the classrooms to provide prevention services using evidence-based practices. They also observe what's happening in the classroom so they can identify children early who might be evidencing some behavioral manifestations that mean that they need some support. And then they also can provide treatment to the young person and their family. I am very proud of what's happening within the District of Columbia. If you look across the country, the District of Columbia is really a leader in this respect. We are one of the few jurisdictions in the country where we make behavioral health services available to our young people in schools.

MR. BACA: Councilmember Henderson, what can we expect in the fiscal year 2024 budget?

COUNCILMEMBER HENDERSON

COUNCILMEMBER HENDERSON: I think everyone understands that we are in a tougher economic position than what we have been in the past, but that doesn't mean that the investments in what is necessary and needed will stop. I think, though, throughout the hearing process, we've heard some concerns that were raised in terms of our needs to address the model. And we've had these conversations with Dr. Bazron. I can have 30 young people who come testify before my committee, and they'll say, 'I have no idea who the clinician in my school is.' And we're paying this person to be there. Are they actually there? And I think also, we recognize that what might work for our elementary school students, our middle and high school students need something very different. They need different approaches. You have to be there in order to develop the relationships. The students haven't been really willing to do the whole telehealth model with someone that they have never met before to initiate those relationships.

MR. BACA: Even though they're used to cell phones and devices?

COUNCILMEMBER HENDERSON: Yes. But I think that this whole conversation around COVID, a lot of young people miss the physical piece of it. I was driving in today and I talked to friends who I haven't seen in a long time, and they're like, 'Oh, I haven't seen you in a month and Sundays.' It's like I could talk to you on the phone, but I need to lay eyes on you. I need to be in your presence to feel whether what you're saying is 100% true or whether your body language is saying something different. But it also is just, 'I've been staring at a screen for three years, I'd like to talk to someone in person, and I can't do that if you're not there.' So we've talked to Dr. Bazron about that, that the clinicians need to be there in the school developing those relationships.

But also there are some young people for whom their mental health is important, but so are the academics. And they might not be willing to miss class. They might want to talk to someone after school. Is someone there after school for that encounter, or is someone there before school for that encounter? I think we are having to think about the different models. But at least for me, for some of my colleagues, the testimony that we received from young people in this last cycle was incredibly impactful in talking about how they want to begin to receive services, how they want to begin to receive interactions around behavior and mental health.

MR. BACA: Well, Dr. Beers, Councilmember Henderson brings up a lot of interesting points regarding children and telehealth and some of the challenges there.

DR. BEERS: Yes. I think Councilmember Henderson points out a really important point. I think we know that school-based mental health services are essential. We know that on a lot of different levels and that it is complicated, and it needs to be individualized.

And we see this across a lot of different types of systems, that we need to make sure that we're providing the supports and that the school-based mental health supports need to be able to do that outreach and to be able to do that coordination because the clinician is too busy seeing the kids, right?

> ***"We need to make sure that we're providing the supports and that the school-based mental health supports need to be able to do that outreach and to be able to do that coordination."***
>
> **DR. LEE BEERS**

I think that gets back to what we are seeing with telehealth as well. And I agree with Councilmember Henderson, it varies for kids.

Some kids really love the telemedicine piece of it. And it gave them the opportunity to see and talk to someone more regularly. They didn't have to go across town every week. They could do it from the comfort of their room.

For some kids, they can do telemedicine, they could step out in the middle of the day at school and go to a private room and do it there. I know one kid who said, 'Oh my gosh, I don't want to do this at school. I don't want anyone to know that I'm receiving it.' So you have to have flexibility, and that ability to respond.

We should continue every flexibility and support for telemedicine that we can because it is really quite important and essential. And we also have to recognize and make sure that the in-person services are available as well. I think there are kids who do really crave that in-person relationship for developing—it's a therapeutic thing for them to have that relationship. I also think for some kids, we have to recognize that there may be confidentiality issues to be working in telemedicine. I mean, imagine you have an LGBTQ-plus youth whose family is not supportive, right? And so to be at home, talking on telemedicine about that, that's not safe for that child. For some kids, they may not have good access to devices or internet access. And to be on a phone trying to talk to someone through FaceTime—that's not great for developing a relationship either. I think it's important to recognize the power in telemedicine and also know that it has to be part of a broader system that we're offering our youth.

MR. BACA: Dr. Bazron.

DR. BAZRON: Yes. I did want to comment on telehealth, particularly during the COVID experience. Our school-based behavioral health clinicians did provide telehealth services. They had virtual spaces where young people could go to receive support, and many of them did. At the same time, remember, schools were not totally closed down. And so youth were also able to receive those services in person during that time. The clinicians did go into the schools and did provide those services.

I actually talked to one young lady who was about to graduate right after COVID, and she told me that her school-based behavioral health clinician was the reason she felt she was at that point of graduation, because she was able to touch base and have that kind of support, both virtually as well as in person. And the thing that was interesting is that the school-based clinician was not called 'my therapist,' she just called her Mrs. X. And that's the other thing to think about, that in schools, you may not be carrying your professional role on your sleeve and saying, Hey, I'm the clinician but, I'm Ms. Jones, and you come talk to me. I think that that's another thing for us to think about in terms of access and knowledge of when you ask the question, who was my therapist in the school?

MR. BACA: I remember in March 2021, I heard a story regarding the challenges of telehealth across state lines. In Virginia, they couldn't see patients in D.C. due to a lack of an interstate compact. Has that situation changed?

COUNCILMEMBER HENDERSON: There's one regional compact for psychologists so we've worked that out. We're working on it for others. The Board of Medicine one just went through. And there are pieces to this, right? I think having conversations with DC Health, as well as the licensing boards in terms of licensing and reciprocities and whatnot, I'm just trying to understand the hesitations around some of it. For example, one of the reasons that it takes so long to get when you do a reciprocity agreement, you basically have to accept all of the qualifications and credentials of another jurisdiction, hands down. And one of the things that was a sticking point for us was that, say, in Virginia, they didn't require a background check for licensing. In the District of Columbia, we do. So are we okay with just waving everyone in not knowing that? So it is an arduous process, but for psychologists, we have gotten it done. On professional counseling --

MR. BACA: A work in progress?

COUNCILMEMBER HENDERSON: Yes. Everybody has different standards.

DR. BAZRON: And some of the licensing requirements were in fact, relaxed during COVID. That allowed for across state-line involvement. But now, we are trying to sort out the best way to maximize access, because this is about access to care, to maximize access to care using the full range of tools that are in our toolbox.

MR. BACA: Dr. Graeden, what are some of the highlights of your report regarding telehealth?

DR. GRAEDEN: The primary highlight is as soon as it was made available, people used it. That was the big take-away message. And, you know, to your point, Dr. Beers, it's not a replacement. It's a yes/and. How can we expand the range of opportunities for people to be accessing care, identifying care? Because there's a huge range in humans about what we need, when we need it, how we need it and that changes, over the life of a kid, as they're developing so rapidly. Little kids need something different than big kids. And they

need those interactions differently. It turns out just texting can go a really long way, right? But these aren't actually mechanisms by which we have great services for medical doctors to use texts in a HIPAA compliant manner. We need access to IT systems to support these things; that requires a lot of upgrades. We're talking about systems-wide assessments and changes that all need to be integrated.

The other piece that I wanted to pull forward, too, is thinking about how we apply what we've learned, say, for nursing licensure across state borders to the telehealth issues and to other domains of care.

These are issues that are being addressed across the entire medical field and what will be interesting to see is on May 12th, when suddenly, the pandemic is declared over.

I think the biggest issue is going to be to identify those things that work well and that are continuing to work well and are serving real needs in the community that it turns out, sure, we triggered them because of COVID, then we figured out they worked. So let's make sure that we don't lose all of those essentially new skills as governance and policymakers that we can be pulling forward into the future.

DR. BAZRON: One of the things that I did want to say with respect to telehealth within the District of Columbia is that it's here to stay, that the Department of Healthcare Finance has promulgated regulations that will allow us to use telehealth, both visual and on your phone to provide behavioral healthcare services.

> ***"With respect to telehealth within the District of Columbia is that it's here to stay, that the Department of Healthcare Finance has promulgated regulations that will allow us to use telehealth, both visual and on your phone to provide behavioral healthcare services."***
>
> **DR. BARBARA BAZRON**

And I also want to share that for individuals who need deep-end services, for those individuals who may, for example, have a severe persistent mental illness or substance use disorder, they need the in-person care. And I don't want us to think that it's a one or the other kind of situation.

MR. BACA: "Yes and".

DR. BAZRON: It has to be an and. And we have to take the time to really assess what the needs are of the particular population of focus. So if you have someone, for example, who really is suffering from some stress and distress and needs someone to talk to, then doing it over the phone or telehealth might be helpful. As a matter of fact, within the Department of Behavioral Health, during COVID we made three visits with

a clinician via our Access Health Line, via our mental health Healthline, free of charge with no need to sign up, because we wanted to deal with the stigma that you've talked about in terms of being thought to have a mental health disorder. And that really worked. And we saw that people took advantage of it. And now we are continuing that with our Warm Line services for individuals in the community.

MR. BACA: Moving on to what Dr. Graeden was speaking about, the challenges of data sets, not having that information from a comprehensive database, what challenges does the Department of Behavioral Health have and what can it do to try to integrate multiple data sets?

DR. BAZRON: During COVID we did put up the COVID dashboard, which tracked a number of factors that allowed us to be fairly nimble in terms of addressing what the needs were of our community and that was very helpful. We are currently in the process of designing our integrated technology engine [ITE], which will give us the opportunity to track and collect data in a consistent format, which I think will be extremely useful.

> ***"We are currently in the process of redesigning our integrated technology engine [ITE], which will give us the opportunity to track and collect data in a consistent format."***
>
> DR. BARBARA BAZRON

We also have put in place a requirement for all of our behavioral health providers to have bidirectional interface with CRISP [Chesapeake Regional Information System for our Patients] which is our health information exchange here in the District, and that means they will be putting data in a certain format and be receiving data. And so here again, that will allow us to roll that information up for our analysis.

We also think that it's very important for us to begin to collect data on the social determinants of health, because we know behavioral health does not exist within a vacuum, and with our new ITE, we will actually be able to collect that. We learned a lot during COVID. I am a real fan of data driven decision-making. I think my staff is tired of hearing me say that, but I am. Because I believe that we really have to look at what the data are telling us and make decisions to address the issues that are identified.

MR. BACA: Councilmember Henderson, on the subject of data-driven decision-making what challenges do you face in the lack of integration of data. And what would you like to see moving forward?

COUNCILMEMBER HENDERSON: Well, I think some of the things that Dr. Graeden talked about in terms of there not being a central repository of information. So if somebody calls the office to say how do I find a clinician, it's like, now we have to go through a variety of questions: what's your insurance provider and network. Do you have Medicaid or is it private. You know, Dr. Bazron and I had an exchange about this at a hearing around how many beds do we have if somebody needs residential treatment? How many beds are available in the District? Is doing it in their same community environment even good for them? Like do they need to go on a little break in Maryland or Virginia in order to deal with this, as opposed to being in the same surroundings where you might have triggers, in terms of substance abuse, et cetera? And I think that's one of the challenges that we face that we're trying to sort of push to get better on--how do we provide more information and more approaches, and we're even having these conversations with some of the managed care organizations as well.

MR. BACA: Dr. Beers, what challenges do you face with the lack of data integration in Children's National hospital?

DR. BEERS: I would agree that these are all tremendous challenges, right? And I think in the same way, that from a system standpoint, we struggle to make data-driven decisions when we don't have really good comprehensive data. We on the clinical side of things face those same barriers.

One of the challenges, to the data that we need comes from it being so decentralized, right? It comes from so many different places. We need the data from schools, and what are the schools seeing about kids? We need the data from primary care. So many kids are coming to primary care as their first point and often their only point of entry to behavioral health care.

Our community-based organizations, what are they seeing? They're seeing a lot of kids who are struggling, who never even get to any medical care at all for a variety of reasons. Our community members, our family members, our family-run organizations, our emergency departments have kids boarding, waiting for beds.

So getting that data from all of those different places—and I'll acknowledge that it's easy for me to say that sitting here—but that is what we need. The actual implementation is incredibly difficult and complex, and that's why I appreciate this conversation, because it's more than just one agency or one organization can do. It really takes a comprehensive whole government approach to do that with public and private partnerships. I appreciate that we're having this conversation because I think that's what we need to be doing.

COUNCILMEMBER HENDERSON: Can I just add—most people don't realize that the Medicaid/Medicare organizations actually have quite a bit of data. The problem of course is that it's only on a sliver of the population. And that is a challenge for policymakers. We could be presented with the data and we have to acknowledge that it doesn't capture everyone. Making policy decisions just on Medicaid patients can lead you in different directions, and it may not even capture the entire scope of something.

In a hearing with the chair of the Board of Psychology, I asked him pointedly, why don't your members take Medicaid? One of the things that we hear from folks is that, I have insurance, but nobody takes it what I need, and so can I actually get the services that I want?

The Medicaid data that we have is limited, because there are a lot of folks who might be diagnosed, but they can't get into treatment. And he said, pretty candidly, that I can make more money with someone who can just pay me without involving any insurance than I can going through Medicaid and Medicare to get back maybe $15 of what would be a $100 session. We haven't gotten to that part of this conversation but there's a question of what does demand look like, and is there even a supply on the other side to meet the demand? On the school-based side, we've had issues with vacancies. And when folks say we just need to add more money I say okay but then the providers tell me, maybe I don't want to work with kids, maybe I don't want to be in a school setting, maybe I don't want to go to a school every day, because I can make more money doing telehealth, or I can make more money doing private practice and having the flexible schedule to not show up five days a week.

There are many different pieces here, and Dr. Beers, it's complicated!

Well, we could spend two hours and just talk about single-payer healthcare systems!

DR. BEERS: What the Councilmember is saying, I think that's so true. It's incredibly important to also empathize with those providers that are telling you that it's not to make more money because they want like a fancy car or something, right?

It's actually paying their rent and their staff and for the people within their office to be able to provide the wrap-around services and the care coordination services. It's really about being able to actually finance a basic level of care and service for them to provide. If you're trying to make a decision about how do I run an office and pay my staff a living wage, and have care coordinators and peer support workers to provide the care that a mental health provider wants to provide. You have to have the money coming in to be able to put that out into your practice and into the care that you're providing for your patients.

It's such an important point.

COUNCILMEMBER HENDERSON: And it's not something that we locally can solve 100%.

DR. BEERS: Right.

COUNCILMEMBER HENDERSON: And if I had a senator or a congressman….The reimbursement rates are painfully low.

DR. BEERS: Yes.

COUNCILMEMBER HENDERSON: And on a variety of things, right? I can say the same thing about how we're reimbursed for school lunch. I think, for whatever reason, we've been doing the bare minimum and not acknowledging nationwide that this is an issue.

MR. BACA: Dr. Graeden?

DR. GRAEDEN: Yes. That's exactly right. And I wanted to pull forward also, that the issue around staffing and beds and finding care providers is not just a mental health issue, right?

COUNCILMEMBER HENDERSON: Oh, no.

DR. GRAEDEN: This is absolutely what we're seeing in nursing across the whole US. It's what we're seeing in this whole care provider network. We talk about the impacts of mental health on the public. It's had a huge impact on care providers. There are a lot of people leaving the profession because they're burnt out, they're not getting the reimbursements, because they're not getting the care that they need. These wrap-around services are critical for the patients. Frankly, they're also critical for our care providers. And we need to be expanding our perception too of who requires that care and how we create a long-term sustainable workforce in this field.

> ***"These wrap-around services are critical for the patients. Frankly, they're also critical for our care providers."***
>
> **DR. ELLIE GRAEDEN**

It's about improving all of those different care components, and recognizing that it's a whole integrated system. The other issue here is that it's one thing to say that I have beds available. And one of the things we

ran into at ICUs was, do you have the appropriate staffing for that bed type in that hospital? And by the way, do you have a ventilator and the auxiliary equipment required for it, right?

> ***"It's about improving all of those different care components, and recognizing that it's a whole integrated system."***
>
> **DR. ELLIE GRAEDEN**

I think it's understanding the whole system and tackling that as a whole, and what we end up doing is piecemeal reimbursements and piecemeal mechanisms to address them. And so where I start, yes, certainly the single payer healthcare sort of solutions, simply because that forces an integration of the information when we have that conversation.

DR. BAZRON: First of all, in terms of rates, one of the things that we recognize in the District is that we needed to do an assessment of the rates that providers are getting for behavioral healthcare. And in partnership with the Department of Healthcare Finance, we are almost at the end of a rate study that will result in establishing rates that cover the cost of service delivery. That's really something that's extremely important to note.

The other thing that I'll share, is that particularly within our school-based behavioral health care program we, like other places around the country we have a workforce issue. We know that. But we have put some things in place to try to the best degree possible, to make these positions much more attractive to the clinicians who we need to support the program.

So in addition to providing more than half of the salaries out of local dollars, we also are providing incentives to our providers to hire and retain the clinicians which I think is helpful. We have a thousand dollars, for example, per clinician rate that will support licensing fees, because, for some of the people who are coming out of school, that's a significant expense and licensed staff have to go and get continuing credits, CLIs, CSWs.

In addition we've established internship programs with three of our universities locally, which includes Howard University, Catholic university and the University of Maryland. And we also have established a portal so that if somebody wants to apply for jobs, we post it, we do this in partnership with the Office of the State Superintendent of Education (OSSE), and they can actually apply quickly and get into the process.

We are not, putting our head in the sand, but we're trying to do what we can to be supportive. In addition, one of the things that's a real salient point for our school-based clinicians is we are providing funding for a supervisor so that the licensed graduates who need additional hours of supervision credit can get that free of charge. If you've gone through school, you know that's a big expense. We're trying to do what we can to have the staff that we need to provide these services.

MR. BACA: Coming back to the subject of data points, we all got a very unfortunate data point just this past. On April 10th, the Chief Medical Examiner issued an alert in D.C. after 24 people overdosed in the 24 hours between April 3rd and 4th. On June 22, 2021, Shaquita McBroom went into her daughter Jayla's bedroom to wake her up for school and discovered the 17-year-old had died of a fentanyl overdose.

Quote, 'My daughter was not a heroin addict, she was not a drug user, and that's what they say about our children, and I won't have them keep lying on my child.' According to the report opiate related deaths have spiked since Jayla lost her life. Last year alone, 448 D.C. residents died of overdoses. That's an average of 37 people each month. The report shows that 72% of the victims are Black men between 40 and 69 years old, with the majority living and sadly dying in wards 5, 7, and 8. Councilmember Henderson, when you hear this, what's your reaction?

COUNCILMEMBER HENDERSON: It's obviously alarming and disheartening, but we've known in the city for years that we've had an opioid problem. It was different than West Virginia. It's different than what rural states were dealing with. We were dealing with pills, with scheduled drugs here. And I think the added difficulty for the District is that the demographics that we're dealing with are older, either they have been living with their addiction for a longer period of time, they tried treatment once and it didn't work, or they're reluctant to try treatment again. And some are unhoused or they're living alone. And so they don't necessarily have the familiar support systems to help them get through that.

We are doubling down on the overall strategy and investments and what we're doing for substance use disorders. We've received money from the opioid settlement, where is that money? It was swept from that fund, but we don't put the money back, and establishing this Advisory Council whose whole focus and function will be around spending this--I think it's $75 million over the next 15 years to truly tackle this issue.

We've put Narcan out, we're doing fentanyl strips. One of the things we'll be looking at on the Council side is how we increase funding for outreach, and making sure that we can staff our crisis response teams and community response teams who can go out and help. But we also have to do the other part around when someone says, I'm ready for treatment, do I have a place to send you to? And right now, I don't know if that answer is yes, because there aren't that many beds.

MR. BACA: Dr. Beers, when you hear the story of the 17-year-old dying in an opioid overdose, what are you seeing at Children's National?

DR. BEERS: I think this is a really important question. It's been very hard and I think the Councilmember is right in that maybe five years ago much of the crisis was in older adults. And I think at least anecdotally in the data we have, what we're seeing is that it's quickly shifted, and we're seeing it much more commonly in our youth.

This is a place where we do really need to better understand the data. I was talking with a Children's resident who's been doing a lot of work with our child psychiatrist, who works in substance use disorders. And this is a plug for a good way to use some of these funds. There's a fabulous idea for actually training primary care pediatricians on how to assess and train and treat substance use disorder in the primary care clinic with the support of the substance abuse experts together collaboratively.

When I was talking to her, she said, we haven't been able to really dig into the data around this. She said I'm noticing that so many of the youth that we're seeing are Latino youth, many of whom are immigrant, migrant youth.

And she said, I don't know if this is just anecdote, like an artifact of the patients we're seeing, but I feel like

that's something that's really important to understand. As you were saying earlier, what works for who and when? So we do need to understand that data. Nationally, it's hard. There's a real dearth of services for substance abuse in youth nationally.

But I think it's important for us to make sure that we have a wide variety of services available. There are multiple evidence-based models that are going to be effective for different populations. It's important to make sure that we have that, but we really—we're, you know, talking to Dr. Kaliamurthy he says he's bombarded with referrals, calls from primary care providers, from community providers, and can't meet the need. And I recognize that it's actually accelerated really quickly, in the middle of a pandemic, which makes it even harder to catch up with the need for services.

MR. BACA: Dr. Bazron, how does the Department tackle this challenge that affects everybody from a 17-year-old to the majority of deaths of people over the age 65? That's such a wide cross section.

DR. BAZRON: Well, we have put some things in place to address the needs. I want to first start with something that I think is critically important, and that is that we have made Naloxone available in every public and school. And we're seeing things like rainbow fentanyl, which looks almost like candy, and young people are ingesting it. And to have Naloxone in schools can save the life of a child. I carry it with me all the time. I have it in my handbag now.

DR. BEERS: I have two teenagers at home and ordered some.

DR. BAZRON: Yes, you have to have it. That's one thing. The other is psychoeducation. Getting young people information so that they can make healthy decisions, you know what to take, who to take it from, and so forth. And we are offering a number of evidence-based practices in our prevention services, Too Good For Drugs and that's one piece of it.

The other piece is that we have moved to a harm reduction focus. Because we know there are individuals who have been addicted to drugs for many years. And back in the day when I first kind of started in this field, it was abstinence only. So if you didn't want to be totally clean, you couldn't get any services and supports. And we have moved away from that. Our goal is to meet people where they are, to work with them to provide that engagement, to provide that care coordination. To have peers, people with lived experience, who can really begin to engage them and help them move through that change process, where they're ready to move into recovery.

> ***"Our goal is to meet people where they are, to work with them to provide that engagement, to provide that care coordination. To have peers, people with lived experience, who can really begin to engage them and help them move through that change process, where they're ready to move into recovery."***
>
> DR. BARBARA BAZRON

And we do have providers within our community who can provide the full range of American Society of Addiction Medicine Services. There is a readiness. We also have public education campaigns. You talked about somebody who tried a program and maybe didn't want to do it again, but we do have a campaign that

focused on 'now is the time,' so people can think about trying it again.

We know that substance use disorder is a chronic relapsing disease, and we know that people may have to go through the recovery process multiple times. However, we want them to have that service available to them. We also will be implementing a new stabilization sobering center here within the District, and we have another one coming online next year. And that's a place where people can go to get sober. If they have been impacted by alcohol or drugs, they will have an opportunity to get an evaluation, to talk with a peer who can work with them around whether they're ready for that change process, and they will have a place to go. They will get cleaned up, they'll get some food, and they can either walk into the center, they can be brought in by Fire and Emergency Services, or the police or a provider or a family member. And I think having that kind of facility available also will make a difference. Intensive care coordination and follow up for those individuals so that we don't lose contact with them I think is important.

The other thing I think is important is at one point, not so long ago, the only funding for substance use disorder services was the SAMHSA block grant. Now those services are a part of our state plan amendment, which means that it now is an entitlement. So we don't have to worry about how much money we have in our budget and when that will expire. If people need the service, they can get that service. We have our state opioid response grant also that is providing outreach as the Councilmember talked about, intensive coordination work with the faith-based organizations, who also are another very important part of our stakeholder community, so that we can get people the care that they need, regardless of their age.

MR. BACA: Dr. Graeden, we've heard about the need for additional funding, but how challenging is it to make the case for spending money on additional data collection and integration and systems? What are the challenges in convincing people that data saves lives?

DR. GRAEDEN: The data just magically appear, right? There are a couple of levels here. When we talk about public health writ large, especially across the US, we know we haven't had national or federal level investment in those systems at nearly the levels that we needed. When we were doing COVID response and doing things like vaccine distribution plans, asking how are we going to get vaccines into the neighborhoods that need them and questions like where do you park your vaccine van, right? The simple questions. We are working with the state of Nevada. My team was the one who pulled up a map and started looking for places where there would be large congregations of people on a Sunday. And where could we find a large parking lot to which we would get public access?

The reason I bring that up is that it also turns out they were working with data out of a 2003 Sequel database. What that means in English is that it was a standard format, think about an Excel file, right? That's the format that it was in that had been built in 2003. I said, okay, got it. That's what we're working with. So be it; here we go. And the response I got back was well, at least it's not still in Cobol, which was the go-to language from the 80s and 90s, right? What I think is worth pulling forward here is that we're talking about large scale infrastructure investments in addition to identifying what these standardized data units are, how we're going to then coordinate those. And on a whole other set of issues that we're dealing with right now on the global scale is data privacy policy, right?

And we can't even talk about upgrading or advancing HIPAA to allow us to do more effective data sharing, which is as important as the privacy side of things when what we're actually running into is our consumer

privacy laws. Now, if you start to think about mouse movements that can be used to diagnose Parkinson's, or you think about VR headsets, and when somebody has a stroke when they're in a VR headset. Well, does the owner of the VR headset need to find a way to call 911?

DR. BAZRON: Coming back to addressing substance disorder needs, I'd be remiss if I didn't share that it's easy within the District of Columbia to get Naloxone as well as know where services can be provided. If you text Live Long D.C. to 888-811, you can get Naloxone delivered to your house. They can tell you where to go to get it and what pharmacies have it available free of charge. The other thing is, you can get information on where substance use providers are located, so you can find somebody who's close to you and actually go to them. You also can get federal test strips. It's important to know that we do have some tools that are out there that can help.

MR. BACA: Now is the time for you to ask questions. If anybody has any questions, by all means this panel is here to answer.

PARTICIPANT: I'm an advisory neighborhood commissioner. How can we advise our community to recognize how to best seek out what they need that may be less easy to find than it was throughout the pandemic?

DR. BEERS: I'll say two quick things. And this is from my perspective as a primary care pediatrician. First, I would really encourage folks to talk to their primary care pediatrician. It's not an easy system to navigate for us either, but that's a good grounding point.

The other thing is that there is a role for us as community members to be connecting families and our neighbors and our community members to services. This is not a challenge that's going to go away just from a few agencies. Each and every one of us can play a role in helping to build safe, strong, loving relationships within our own communities and within our own systems. After school activities, library activities, all of those things make an enormous difference. And they're not the kind of things that any of the four of us can effectively do and implement at the hyper-local level. And so I encourage everyone to think about what can YOU do. What can you take ownership of within your own community?

> ***"There is a role for us as community members to be connecting families and our neighbors and our community members to services. This is not a challenge that's going to go away just from a few agencies. Each and every one of us can play a role in helping to build safe, strong, loving relationships within our own communities and within our own systems."***
>
> **DR. LEE BEERS**

DR. BAZRON: We do have access online and we have a mental health Line 1-888-7-WE HELP. And if you call that number, then you can get information on the full range of mental health and crisis services. The other thing, as I said before, if you text Live Long D.C. to 888-811, you can also find out information on substance use treatment services.

The other thing is we have outreach staff that will do presentations better tailored to the needs of your community. This evening, I'll be out there talking about the budget, for example, in one of the communities.

And that's a part of our role. We also have public education campaigns that are very prevalent throughout the community. I mean, if you go to a gas station, you might see me on your gas station pump talking about how to use Naloxone. But certainly please be in touch with the Department of Behavioral Health so that we can support you.

PARTICIPANT: I'm thinking behavioral health feels a lot like an antibiotic, which is how do you know whether you've gotten enough? Is it not working because we don't get enough should we try different antibiotics. So Councilmember Henderson will know that the reason I'm asking this question is because she's being asked to parse out dollars. And the question is, are we going to spread them out and not give enough of the dosage? And how does she get the information to make choices about should we put more money into something or should we try a new model? I mean, this is a school-based behavioral health question, right? That Dr. Bazron's trying to figure out how to strengthen that network. It's the beginning of something. Or does the model need to be looked at? So that that's really where I'm asking.

DR. BEERS: And I think it's an incredibly important question, and an incredibly difficult question. And again, I'm going to speak from the perspective of the person who doesn't have to control the dollar. So I think, lots of money into everything is ideal.

But one piece that's really important that'll help us make the decision is to take a step back and to look at the entire continuum of care and services that are being provided. There's the Institute of Medicine continuum from health promotion all the way up through early identification, various types of treatment and then recovery from treatment. And really take a step back and look at that entire continuum of services and what's being invested, where and what's working, where and how things are interconnecting.

Because I think that's going to help give us some of the answers of, okay, well, this particular thing isn't working, but maybe it's not working because it's not actually connected to the next thing. I think we have some amazing programs here in the District and there are gaps along that continuum of care. Dr. Bazron doesn't have an unlimited budget—I wish I could give her an unlimited budget. But I think that's how we can understand where we need to invest more by looking at it across that entire continuum and seeing where the gaps are and seeing where our gaps in connections are.

COUNCILMEMBER HENDERSON: In thinking of models, what I talked about with middle and high school kids, perhaps there needs to be an intermediary before you get to the clinician to suggest, hey, the clinician might be the person that we need to talk to. And could that be a peer to sort of make that connection?

And looking at what has happened on, say the sexual health side where we've been able to see these great decreases in terms of teenage pregnancy and STIs and young people getting tested, because we have invested around peer education, public education, and just writ large. And I think let's not reinvent the wheel. If the model has been working, maybe we should try to replicate that in other places.

And even around substance abuse, what we're seeing in young people, you know, when I was a kid, we did DARE. I'm not suggesting we do DARE. What I am suggesting though is that through technologies and other things, we need to have more direct campaigns to young people around the harms around substance abuse.

You know, we had some elementary school kids a couple of weeks ago who ingested cannabis because they thought it was a gummy bear at school. Nobody wants to say they don't want to have conversations with

their 7-year-old about drugs, but it needs to be a conversation around perhaps you shouldn't ingest something that you don't know what it is. Or you don't know where it came from. Or those kinds of things, right?

So what I'm thinking about in terms of the model is not getting rid of it but it's like we need to tinker with it.

PARTICIPANT: D.C. schools, like a lot of places had really high rates of chronic absenteeism for this pandemic. And a lot of these kids who aren't coming in are suffering from depression or anxiety, which is only getting worse the longer they stay out of school. Is there any effort for the clinicians or anyone to reach out to kids who aren't making it to school to get them back?

DR. BAZRON: I think that your focus is on what are the outreach strategies being used when public schools also provide outreach services and supports to young people who are particularly chronically absent. And here again, remember our school-based clinician is a part of an overarching team within that school. And they certainly can interface and provide the supports that the school builds that they can offer.

COUNCILMEMBER HENDERSON: I think for some, the original is a school calling. Where are you? But unfortunately, our laws are the way that our laws are. And after a certain number of absences, then the government gets involved and it may lead to okay, so you're dealing with depression, anxiety, et cetera, let's get you services through CFSA, going that particular route. But at least the way that our overall truancy system is designed, a young person of a certain age can't just disappear with no one saying, "I haven't seen you in 30 days."

DR. BEERS: I would also add, certainly this is something we think about from the primary care side of things, though, often particularly for our older kids, if they're not coming to school, they're not coming into primary care either. But I want to emphasize that this is where really meaningful substantive partnerships with our community based organizations and family run organizations are incredibly important because those folks know their communities. They know the kids in their communities and they're going to be some of our best connectors to families and to young people to engage with them where they have the resources they need, I think is an important strategy.

MR. BACA: If I may, Dr. Beers could you talk about primary care?

DR. BEERS: Just to clarify, this is really more conceptual than something that's actually been implemented yet, but I think your point is exactly right, that the primary care pediatricians are not ready to do this right out of the gate. They need support and training and partnership with integrated care providers, who are mental health specialists in substance use disorder.

So I want to emphasize, I don't think we should do it on our own. And we're not ready to do it on our own. But I think it does speak to the importance of thinking about how we upscale all aspects of our workforce so that we can be better prepared to support children and youth with behavioral health concerns. And how do we create that connectivity to our specialty mental health providers, so that we're able to get kids the appropriate level of care where they need it, and not overwhelm our scarce resource of child psychiatrists and psychologists and other mental health professionals who have expertise in childcare. So we need to think about the continuum.

DR. BAZRON: In terms of the primary care framework, there are some efforts where there are hotlines, for example, for primary care physicians to call to get consultation services and supports around behavioral health. And I think that that's a strategy that is working in various communities. We have a similar kind of call process around substance use disorders, which is funded through our SOAR grant. And so I think there are some tools that are out there to do that.

In terms of the rollback of the legislation around medication assisted treatment in particular. And here we are waiting for some final information from SAMHSA. As you know, the MAT dosing process was relaxed significantly where we were allowed to do curbside dosing. We were allowed to expand the take home process, which did work extremely well. However, we still need to make sure it's paired with the counseling support that needs to go along with it. And so we know finally what's going to happen. I do know in talking with the assistant secretary, they're looking at what the permanent requirement should be for our state opioid treatment authorities and so we'll stay tuned.

MR. BACA: I would like to thank this entire panel for making all of us more informed about mental health/behavioral health substance abuse issues with D.C. So thank you. Joining us now is Auditor Patterson to talk about what is next.

AUDITOR PATTERSON: Thank you so much, Nathan. Thank you to our panelists. Thank you for identifying some of the ongoing work including the interstate compacts to help us continue to do Telehealth. That's news to me, and I'm glad that's underway. And thank you for noting the consensus definitions we need in order to collect the data in order to use the data. There's just lots more to be done! Thank each of you for the work that you're doing in these areas.

We at the Office of the D.C. Auditor, have a couple of additional COVID reports in the works on other topics. One is an audit of the District's expenditure of the first bucket of COVID money, the first $495 million that we got through the CARES Act, and that will be finished up in the next month or so. And then we have another looking at how we handled COVID in our nursing homes in the District of Columbia. We put out an audit a couple of years ago that was fairly positive about the Department of Health's oversight of our nursing homes. And we thought it'd be very useful to see if that held up in the pandemic in terms of patients and staff and cases we've seen. Thank you to Georgetown. Thank you to our researchers and thank you to our panelists for your work here today, but also thank you for the services you're providing each and every day. Thank you all for coming.

About ODCA

The mission of the Office of the District of Columbia Auditor (ODCA) is to support the Council of the District of Columbia by making sound recommendations that improve the effectiveness, efficiency, and accountability of the District government.

To fulfill our mission, we conduct performance audits, non-audit reviews, and revenue certifications. The residents of the District of Columbia are one of our primary customers and we strive to keep the residents of the District of Columbia informed on how their government is operating and how their tax money is being spent.

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