HEALTH SYSTEMS DIVISION
Behavioral Health Workforce Initiative, House Bill 2235 Workgroup
Tina Kotek, Governor

Oregon Health Authority

500 Summer Street NE
Salem, OR 97301
https://www.oregon.gov/oha/HSD/AMH/Pages/HB-2235-Workgroup.aspx

House Bill 2235 Workgroup Minutes
May 15, 2024 1:00 – 3:00 pm
Location: https://www.zoomgov.com/j/1618065772?pwd=M0pDZFRIcXVURGc2dFgzRFl0ZkNtQT09

Members in Attendance:		OHA Staff in Attendance:
☒ Belindy Bonser	☒ David Geels	☒ Vitalis Ogbeama
☒ Kelli Bosak	☐ Qurynn Hale	☒ Tim Nesbitt
☒ Chris Bouneff	☒ Clark J Hazel	☒ Jen Allen
☒ Cheryl Cohen	☒ Jenn Inman	☒ Daniel Page
☐ Sarah Conyers	☒ Tony Lai	☐ Kelli Taylor
☒ Deanna Cor	☐ Lucia Mendoza-Meraz	☒ Mireya Williams
☐ Anthony R. Cordaro, Jr.	☒ Shyra Merila	
☐ Lorie DeCarvalho	☒ Dr. Tara Sanderson	
☒ Melinda Del Rio	☐ Sheri Selander	
☐ Jose Luis Garcia	☐ Mario Cardenas	
	☒ Diane Benavides Wille	

Resources:
HB 2235 Draft Charter

START	TIME	END	TOPIC	OUTCOME	LEAD(S)
1:00	5 min	1:05	Welcome Community Agreements Review	Grounding	Tim Nesbitt
1:05	5 min	1:10	Roll Call	Establish quorum	Kelli Taylor
1:10	10 min	1:20	Public Comment Period	Public testimony	Jen Allen
1:20	5 min	1:25	Matters from previous meeting - Alternate date for 6/19 meeting - HB 2235 highlights	Consensus	Vitalis Ogbeama
1:25	10 min	1:35	Tentative Roadmap	Inform	Tim Nesbitt
1:35	30 min	2:05	David Geels Presentation	Inform	David Geels
2:05	10 min	2:15	Break		
2:15	30 min	2:45	David Geels Presentation continued	Inform	David Geels
2:45	15 min	3:00	Wrap up		Tim Nesbitt
			Next meeting:	**June 5, 2024 1:00 – 3:00 pm**	

MEETING MINUTES:
Tim Nesbitt – Welcome, agenda review

Group – Community agreement review

Jen Allen – Roll call and minutes approval; quorum established and minutes approved from 4.17 and 5.1 meetings.

Jen Allen – Public comment by email.
#1 – My name is Debbie Kirby and I'm a clinical director and hiring manager of a small, private for profit mental Health Organization in rural Coos County. I'm beyond frustrated with our licensing boards, both LCSW and LPC. We just had a transferring from another state clinician approved this Monday after almost eight weeks of back and forth with the LPC board. Likewise, someone local is just trying to see if her degree will qualify her to apply to be a clinician since September! Note she still doesn't have an answer. We have someone in our county who wants to become a clinician and six months later her own board hasn't produced answers they can give her direction.
Last year the LCSW board took over six months to approve 3 CEU hours. It took seven e-mail requests to find out where they were in the process. We also have struggles in getting our CSWA re-approved in a timely way before our OHPCCO starts telling us she won't be able to see clients if we don't get approval, that was requested six weeks before.
Recruitment in the private sector is completely on us, same with salary. We struggle to be competitive with hospitals, clinics and FQHC with salary and benefits same as recruiting efforts. We understand (we think) we can't offer hiring bonuses, but we know that others in our area are and we lose out more often than we win them. Housing in Coos County is insane for fresh out of school looking for work. The amount of rent, availability of reasonable conditioning housing, and affordability of buying is out for most new clinicians and some established. As a private entity, we have virtually no access to grants or other community funding. Private clinicians and practices are increasing due to politics and difficulties rural clinics are dealing with due to COVID fallout.
Then there is something as simple as being credentialed as an ADSS for the state of Oregon. It's taken over two months to have a clinician credentialed by them and another one was three and a half pushing four months.
#2 – OHA should bring in OHP covered providers, including in all rural areas for autistic adults of all levels. This population of patients suffers severely from the lack of expertise and understanding of adult autism and often are mistreated and neglected by the current healthcare system. Find primary care doctors as well as psychologists, etcetera, who are autistic as well as those who are experts in helping autistic adults. Attract and retaining by offering higher salaries, longer appointment times and tele-visits as the norm for these providers. And please be sure that plenty of them are women. In general, OHP needs more licensed clinical psychologists rather than relying mainly on social workers and similar who do not typically have the expertise necessary for these and other populations at highest risk.
#3 – My granddaughter has two jobs and is going to school online to be a drug and rehab counselor. She loves working at a rehab center but she must keep her Starbucks job as they are paying for her online schooling. She may have to quit the rehab center because of too much on her schedule. If rehabs could pay for online school, she would not have to leave.
#4 – I suggest the group look at licensure requirements and compare them to other states and also try to improve wages. My daughter has a master's in marriage and family therapy, but the licensing process at low wages took so long she ended up working from home in a property management job, which pays

better yet doesn't require any college. She's buried in student loan debt and can't afford to take a low counseling paying counseling job and pay for supervision to be able to get licensed.
#5 – Establish programs throughout the state so as to encourage graduating students to remain in the given area. Older students, especially seeking to further their education, bring along spouses and family and once established in a community may be less likely to move on. Set up grants or loan repayment programs, much like the Indian Health Service does for medical students, and in exchange require a two or three-year service commitment to practice in areas of need. I feel that addressing our mental health crisis would go a long way in dealing with other crucial issues such as homelessness, drug abuse, domestic abuse and health issues such as STI and TB. Yes, it would require funding, but we must consider the cost of not dealing with the problem as well.
#6 – To the members of House Bill 2235 work group:
Thank you for your continued effort to improve the behavioral health system in our state. I wanted to offer some testimony on behalf of Oregon AFSCME as our union represents nonprofit behavioral health workers across the state who often deal with unsafe working conditions, low pay and poor staffing levels – issues that all intertwine. As we anticipate potential changes and an increase in clientele entering the behavioral health system stemming from the re-criminalization of drugs in our state, it is important to equip our frontline workers with the resources and support necessary to provide quality care for our most vulnerable communities.
Oregon AFSCME has been looking at raising Medicaid reimbursement rates for specific portions of the behavioral health workforce, with provisions mandating increased rates will go to wages to improve recruitment and retention of behavioral health workers. Please consider recommending this to Oregon State Legislature for the 2025 legislative session, along with other recommendations that will enhance the safety of behavioral health workers and ensure workers have a living wage in the industry. Without addressing these issues, recruitment and retention problems will continue to create a cycle of poor behavioral health outcomes in our state.
Thank you for your time,
Kendy Schwing (She/Her) Oregon AFSCME Council 75.

Tim Nesbitt – Public comment period. None

Vitalis Ogbeama – Matters arising from the minutes/previous meeting

Diane Benavides Wille – Request for clarification on a public comment

Tim Nesbitt – Rescheduling for Juneteenth; House Bill 2235 review. HB 2235 states that no later than January 15th, 2025, the Authority shall report to the Interim Subcommittee of the Joint Committee on Ways and Means Related to Human Services in the manner provided by that statute. The Work Group's initial recommendations for addressing behavioral health workforce challenges to inform the Subcommittee on the Authority's budget for the Biennium beginning July 1st, 2025. So I am recalling this to everyone's attention just to indicate that there is a differentiation actually between the two reports that we will have. just to indicate that that's why we sort of drive the conversation towards like something that we've been calling investments. We use that word to indicate what OHA can basically influence with money that's given to us by the legislation. Examples include our loan repayment program, other recruitment, workforce development strategies that we might come up with that OHA can use money to pay for. That doesn't mean that if there's policy recommendations that we won't add that into the report. It's just that this first report is more having to do with the Oregon Health Authority's budget. Subsection 6, it says no later than December 15th, 2025, eleven months after that first report is due, the Authority shall submit a final report in the manner provided by that statute containing the work group's final recommendations including recommendations for legislative action. So therefore that second report is called to have more of a focus on legislative actions. Policy changes, so laws that could should be considered to be changed, administrative burden, rules that need to be addressed, stuff like that. So it doesn't mean that one thing can't be on the second report that and then the one thing that's on the second

report can't be on the first report. It's just that there there's more of a focus in that. And the reason being is that these dates are a bit strategic here because the January 15th, 2025 date is where the legislation will be able to approve the budget for the biennium because OHA like the rest of the state works off of a biennium budget, state budget. So that means every two years we get our budget approved. And then we have our December 15th date for 2025, again strategic as well. So that that gives the legislation more time to review the recommendations from the report and to work on drafting up House bills and Senate bills that reflect any recommendations that we might have that would come from our report. I just want to take some time though, if anybody's got any questions or comments about that.
Cheryl Cohen – Yeah this is really helpful. I didn't realize this before and I thought previously that identifying funding streams was outside of the scope of this group. If I have it right, it sounds like this first report that is going to be the first report with recommendations in the first year is more around making some funding recommendations that are kind of in the purview of what the OHA typically funds, am I hearing that right?
Tim Nesbitt – Yes, and if there are recommendations for things that we haven't funded as well in the past too. It doesn't have to be based on the same thing that already exists that you know we might want to expand upon, it also can be things that we haven't looked at before.
Cheryl Cohen – So things that are broader, more policy level, things like recommendations around licensure board alignment or things like that are probably things where if this group has those sorts of recommendations, it might fall in Year two's report, right?
Tim Nesbitt – Exactly.
Cheryl Cohen - But I'm wondering if as we're working as a group if we're tracking coalescing around a possible recommendation. There are some things that I think are kind of obvious like our licensure boards aligning with each other to the greatest extent possible. Where I'm wondering if we can have someone at the OHA keep track of those recommendations or if there can be a central document or a way of tracking year one report or year two report recommendations. That's more of a policy recommendation. But I have a bunch of things swimming in my head and I'm wondering if we can track those things.
Tim Nesbitt – We do have a tracker that we keep that has it actually pretty well organized in my opinion. Today we had another person, Craig Mosbaek, they are the person who wrote the 2022 wage study report that came out from Health Policy and Analytics here at OHA. He's got some experience in managing reports and they commented on our form, and we do want to bring it back to the work group once we have more of those recommendations to make sure that we have not only consensus but also that we got the language right and our understanding right. Based on the recordings and on the minutes, which are almost verbatim. We try to be as accurate as possible in those things. But yeah, we will be circling back to those especially before these reports are due of course.
Jenn Inman - A question about the Authority's budget, and that is in terms of the funding stream to the revenue streams available to the Authority's budget and if that's exclusive to general fund or if it includes other funding streams. And second, does this limit recommendations that fall under the Oregon Health Authority rather than outside of the Health Authority but that are other state entities? For example, if we have recommendations that are specific to higher Ed state education, or the Ombudsman's office under the Governor's office, does this limit our recommendations to the revenue sources that are in the Oregon Health Authority's budget? And how do we deal with any suggestions that might fall into another agency's budget? And does this include any revenue stream that would fall into the Oregon Health Authority's budget or are we really talking only about general fund?
Tim Nesbitt – This would be related to any to funding streams that would fall under the Oregon Health Authority's budget, and if the funding stream is unknown, that is not as important as being able to indicate what needs to be funded. If we've come up with recommendations that are outside of OHA's scope, such as the Higher Education Coordinating Commission (HECC), we will put those recommendations in the report. We should not limit our recommendations to a specific budget, agency, or partnership, but provide recommendations that indicate both what needs to be funded and improved.
Jenn Inman – Are the boards under OHA or are they under another entity? {Tim indicated no with a head shake} That conversation is a recommendation for a budget that's outside of that statutory language, but it shouldn't limit what we're going to recommend.

Tim Nesbitt – That's right. We're going to review the tentative road map, due to the availability of guest speaker schedules we are still working on speakers and subject matter. This is a topic map that is flexible and open to revision and workgroup considerations. David Geels, the floor is yours.

David Geels – I'm David Geels, the Behavioral Health Director here at Coos Health and Wellness in Coos County. I've been running an employee here for about 20-30 years, and the director for about 13 years. I've seen mental health really just explode in terms of its size and depth and presence within the healthcare world. I worked originally when as an Oregon Health Plan demonstration project I started, which was a number of years ago, for a number of years we were the mental health delegated organization until that got subsumed under the CCO and then even for a while we were delegated under the CCO to manage mental health benefits for a period of time. Now we're more of a provider area and typically community mental health programs are largely the safety net. They do a number of key services related to mental health, typically the crisis system is the CMHP responsibility. We also do pre commitment work, we need to protect the service investigations for vulnerable individuals with mental illness. Typically we run high intensity services like assertive community treatment, early assessment and alliance, intensive in home behavioral health services for kids and those kinds of things. So really it's those high level intensive services, a lot of us have very strong relationship with child welfare, with community corrections, with local hospitals, with the state hospital, with residential care that's sort of the bulk of what we do.

Caveats to be aware of, the health system is so complex, I'm providing my perspective and if you see corrections needed or errors please point them out. Presentation represents the CMHP perspective and those that are certified organizations by OHA.

I really want to focus on one of the primary areas of shortages in our workforce for community mental health programs and that is master's level therapists and counselors. Well, we may have other issues with shortages in other areas like peers and associate level, it's really the masters level clinicians that are the hardest for us to fill and in community mental health programs, those people have a very broad range of job duties that are often very critical to our organization. And when I talk about masters level for us include people that are independently licensed like LCSW, LMFT, SLP, CS, associate providers, they're under a licensing board, but they're not fully independently licensed. So a CSW, SLP, C&L, and LMFT associates as well as qualified mental health professionals, those are individuals that are actually certified by a different board that's MHACBO or the mental health and Addiction counseling board. Those individuals are only supposed to be working within approved OHA organizations. So that's community mental health programs and other COA organizations.

And then also we have some ability to work with student interns, graduate interns, people that are in school, completing their graduate degree in a mental health field, but they're still in school at the time. And so we have some ability to use those individuals in a limited fashion with a little bit more supervision and oversight as well within community mental health programs and other COA organizations, masters level clinicians, Dr. the entire treatment in many situations.

So we hire a lot of associate staff and peer staff and it's really the QHP that has to write the assessments and write the treatment plans and direct the care. If we don't have those individuals then the other team members can't actually deliver the care that we need. They're directed by the QHP staff in terms of their activities. And when we have shortages in those staff, the other team members are not able to do their jobs either. Also, a lot of our clinical management positions are also performed at the same levels. So a lot of our program managers, clinical directors, all of those positions also require somebody with a master's degree in the behavioral health field.

We have within my organization which is fairly small, I have about 60-65 clinical staff directly. We have about 10 vacancies on the QHP side. So you know what is that about 15% of our workforce is in vacancies right now. We were doing better for a while, I would say early sort of mid COVID and I thought we were making progress. And then the last I would say year or so we are back up to probably the highest level of vacancies we've had in these positions and that's across the board. So that's including our crisis team. I've got a couple of vacancies in my crisis team. I've got a vacancy in my assertive community treatment team. We've got one in our intensive in home behavioral health for kids. And so it's really across

the board. I've had several manager positions that have been vacant as well and so that's made it very difficult to maintain operations.
At the same time, what I've noticed there's been a huge growth in the individuals serving in private practice in our community. There was a time where we maybe had a dozen, maybe a little bit more in private practice. We have nearly 50 to 60 individuals working in private practice. And I think we have lost a significant number of our workforce to private practice settings. And I thought I'd share with you just one example of what happens and this has really been as a result of COVID, There's an organization called Stronger Oregon. This is just for example, they're not the only ones, but they're probably one of the most vital options. A number of years ago this was not an organization or had very little presence and they have really grown tremendously.
And so a lot of my staff that used to work here, many of them have moved to Stronger Oregon to work and there are certainly good reasons why people would choose to do that. So I counted up there are currently 160 or more clinicians under Stronger Oregon. So if you look, you can go through their website and you can see all the folks that are signed up. We've got all different profession levels, associates, fully licensed, sort of everybody, LPCS, social workers. And I when I read this, I look and I recognize a number of my former employees now working for Stronger Oregon and I can't say I don't understand why they go there. Their marketing is actually pretty good here. If you look to their marketing site, they say, hey, would you like to be paid a fair wage where you can actually survive and thrive? License. In Oregon, clinicians can make between 62,000 and 160,000 annually based on the preferred compensation structure and hours of direct service you get to choose and calibrate. Would you like to work only three days a week, having four days off in a row for the rest of your career? Alternatively, you could drop your child off at school every day and pick them up only to work during school hours. Do you like free training for being full time? Would you like to help solve the mental health crisis across the state by removing barriers.
So this is their marketing approach and it's actually very, very effective as our workforce would love to be able to choose their hours and time when they want to work. They would love to have as much control over their work schedule and so this offers that ability to do so. They also offer different types of packages depending on how you want to proceed. You can work full time. You can work part time, you work as an employee. You can work as a contractor. So you have a really a menu, a menu of options that you can choose from and you know the wages are good. So you know if I if I wanted to go into private practice I could if I wanted insurance and dental and I could make $110,000 scheduling about 24 hours of work of clinical work. You know if I'm more willing to take a risk and only get paid more on a commission basis, I'm also free to do that. When I look at hiring workforce, I look at my competition around me and this is one competition area that I really don't have a lot of answers for. And that's in true in general in the private practice world. I mean the rate structure for OHP now is, is very good actually if you're working in a private practice setting, I think the fee for service rate for therapy is $178 for a 53 minute and above session. And then some CCO's actually pay a differential rate for their providers, network providers of 1.2 times that amount. So if you just do a simple math and again obviously in private practice you've got a lot of variables. But if I work 24 hours a week and I make $178 an hour and I work 50 hours a week, I can make a gross of $214,000. Now, obviously I got to pay my insurance. If I take a vacation, it's on me. All those things are true. But that's a large amount of money to start. My business with is $214,000. And if I don't want to do any of the business work and I want to leave it up to somebody else, I can sign up for Stronger Oregon. They'll do all my billing. They'll bring all my clients. They'll provide my electronic health record. And I don't have to do anything else but direct clinical work as whatever schedule I want to keep.
So what I've seen here locally is that in the last number of years currently there's two large group practices, both of them have nearly doubled the size in the last couple of years. Others two fully qualified health centers and one of them in particular has doubled and tripled in size in just their behavioral health unit. And if you don't know, the federally qualified health centers have some financial advantages through their prospective payment method, so they can backstop anything. They end up paying out in salaries through their qualification as a FQHC. We have two tribes locally, they previously had no mental health services available and now both of them do, and one of them is expanding. They have a clinic operating about 3-4 blocks from us and they offer also very significantly high standard salaries. There's no way that we really are able to match those salaries. And we have lost, we lost a recent employee who decided to

go work for the tribe. We also see associates being used across all settings. It used to be that really LPC Associates and LRT Associates had limited private practice ability to bill. That's just not the case anymore. Associates have almost the same equivalent way to bill and get reimbursed for many insurance companies as fully independently licensed folks. We also see QMHPS being used in non-approved settings. Now technically this is not supposed to happen, but our people are very creative and they hire QMHPS in certain settings that don't necessarily require a billing. So we've seen some of our staff that have been QHPS that historically only could work for us have now found other opportunities in other settings. And again, I know that we have at least fifteen former employees currently employed in private practice and many of these no longer live in our community either because of the work with the telehealth requirements. I had one that just worked here and she moved to Utah. So she's seeing her same client base here locally and she has no local presence. And I have another one that's moved to Eastern Oregon. We're along the coast, she's nowhere near us and she has basically retained her private practice that she developed here in Coos County. We're also having to compete with CCOS. The CCOS often hire a number of masters level clinicians either behavioral health directors or intensive care coordinator directors. Quality assurance folks. A system of care coordinators a variety of roles and certainly many hospitals and emergency rooms hire masters level and particularly social workers. I'm hoping you all can see this a little bit.

So I just had a little bit of a fun game you know. So you know why wouldn't I move to private practice. I'm a master's level therapist I've got a license. Why wouldn't I get to work my hours? I want to want to work. I get to set my own schedule. You know, I can really help dictate how my life works. And the community mental health response to that is, yeah, maybe, you know, maybe you can do that. But sorry, we really need you to work this shift. We've got a crisis shift going on. You know, we have people coming in at all hours. So we have to dictate your schedule to some degree. Private practice. I get to create a predictable schedule. I can do 55 minutes, 53 minutes, hours. I can schedule my breaks. I have people show up at my office on the hour and it's a very, you know, very contained known quantity which makes me feel relaxed. I know what my day is going to look like. Community health programs and COs, sorry, your work is not predictable. You see whoever comes in and you don't necessarily know what your day is going to look like. In private practice, I get to see the clients I want to see. I screen others out. I write my little blurb about who I like to see and who I'm good at and those are who I see. And community mental health centers, often it's not that way. It's often we see whatever walks in and then we try to provide the support necessary for our staff to be able to deal with whatever comes to the door. In private practice, usually we see clients who are motivated that seek us out. They call us, they look us up on the health grades or from their friends. They seek us out and community mental health programs, many of our clients are mandated. They may not have clear motivation for coming. Sometimes they're referred by child welfare or forensic programs, and so that creates some difference in motivation which also impacts clinicians to feel less impactful, less successful sometimes in their work. In private practice, generally, people show up better. You develop long-term relationships with people; they get to know you. In community mental health programs, our no-show rates are high, they can be 25% up to 50% in some programs. We spend a lot of time just building outreach, motivation, and helping people begin to engage in care. In private practice if someone is too acute, generally, we refer them out, say, "Yep, sure, you're more than I can handle right now. You know, I'm only open these hours. I don't have a crisis response." And in the community health program, that's what we do. We take on those folks. And so we end up being the safety net for the community providers that don't want to take the folks that are more acute in private practice.

If somebody's in crisis, we tell them, "Hey, call 911, call 988, call the mobile crisis team." Being in a whole program, that's us. We are those things. In private practice, if someone no-shows too often, generally, we close them out, refer them out, say, "Well, it looks like you're not quite ready for care yet", typically can't charge for no shows with Medicare. In private practice, people, if there's too many no-shows, we'll generally close those individuals. I mean, in health programs, our goal is generally not to do that if we can possibly avoid it. And so we spend a lot of time trying to engage individuals that are difficult to engage in private practice. There are actually little extra administrative requirements. Obviously, you have to fill the requirements of your licensing board around documentation, there's requiring around billing and what's

required there. But those rules are fairly loose in private practice documentation. There's no generally required standard around documentation other than what your board requires in community middle. However, I'd say the tongue-in-cheek "you need to enter this into Red Cap" - that's a bit of a joke but if what I'm basically saying is that we have a lot of administrative requirements that impact different programs and one of them is this database Red Cap. Certain programs have to enter a whole set of data on top of whatever documentation we have to do, normal documentation that we might have to do in private practice. Generally, we don't have a supervisor, we don't have a director, we don't have a boss. And our response is the support's good, right? In community health programs, you have a lot of bosses, a lot of people that impact your work. In private practice, over time, you develop a highly personal relationship with a set of established clients. We see this other sort of care in different settings, like people who cut hair, for instance; they develop a clientele over time that is known and predictable. People in private practice often create the same kind of clientele. In community mental health programs, we don't usually allow that. We have people waiting at our door, people in crisis. So generally, we move. We tell our staff, "Hey, this person is sort of good enough, they're Band-Aid enough. It's time to move them to something else and take on the next individual that is in crisis or needs our services." In private practice, you don't have to leave your home if you're doing telehealth, you don't have to leave your office, for the most part. In community health program responses, you like to get out of the office, right? And you know, that letter from asks me about safety really comes in here as well because when you're working out in the community, you don't necessarily always have backups. If you're working in a residential setting, safety is also a concern, and it does create more stress for clinicians potentially being in situations that are not safe. This is just a little visual of some of the things that impact staff working in community mental health programs and COA organizations.

Again, there's a lot of administrative overhead. We're organizations with a lot of rules. Some of us are not in our county, and so there's a county level. We typically have purchasing processes, contracting processes, board leadership approval, HR, union legal counsel, liability risks. There's a licensing and certification process, reviews, audits. We all know in organizations the 309 Oregon administrative rules, they govern what we do. I would say there's, I think, 172 definitions in the OARs that apply to us, something like that. We have to have a lot of provider and consumer policies that are required. And then if you're in certain organizations like Certified Community Behavioral Health Centers, if you're getting a certification through an organization like CARF, there are additional requirements. And then also, we have requirements around adult foster home licensing. Protective Services work also has separate licensing and certification requirements. Typically, our organizations have a lot of quality requirements. Typically, many of us run the Quality Assurance committee, risk management structure, chart reviews, audits, and a lot of required trainings and continuing education. Protective Service supervision requirements are also common. There's a lot of supervision requirements. Many of our programs that are what are called fidelity-based programs, these are ones that are certified separately by a Center for Excellence that contracted with Oregon Health Authority and Health Systems Division. These are generally annual reviews. We have specific benchmark requirements and we are held to each of those benchmarks. There's typically also additional reporting requirements for those programs. They're very administrative intense programs. They are the highest level programs, they are the most intense, but they're also the most scrutinized and overseen as well. We have a lot of contracting things that we do. We have intergovernmental agreements with the state of Oregon often. We have CCO contracts also that we're trying to manage. In addition to the normal commercial insurance and Medicare contracting requirements, typically we have a lot of contracts with housing, employment, and other service providers to help support the work that we do, which is primarily helping people be successful in their communities. And again, I mentioned there's a number of reporting requirements. I think we fill out between 15 or 20 quarterly spreadsheets every quarter. In addition, there's a MOTS which is a state monitoring and outcome tracking system that we report. Redcap is one example of an external report. E Cans is another example that we do. OHSU and PSU are two of the state's favorite backings are in terms of our data requirement. Sometimes it feels like we're running more research projects than we are in terms of actually real valid reporting. We also have additional CCO compliance reports. So the state also puts a lot of requirements on CCOS to report certain things. Those

data requirements often get pushed down to us, especially when it comes to things like crisis services, assertive community treatment. So that's another area where we feel a lot of administrative work.
I want to talk a little bit about engagement and care. I touched in that briefly that, you know, in private practice settings generally the individual who's seeking care is self-directed, right? They're taking steps themselves to seek out and get help and wanting something fairly concrete. Often times, for us, there's much more of an external locus of control where it's not coming as much clearly from the one individual that might show up at your doorstep. Child welfare where the primary referral for child welfare cases a lot of times a lot of us have a lot of connections with community corrections and courts. We are very involved in the people that are unable to aid in their own defense in the criminal system. Also, people have been pled under guilty except by reason of insanity. Those are also folks that are generally under our umbrella. Our crisis team also brings in a lot of folks that may not want to be here but because they were encountered by our crisis team, we touch on them. We do a lot of outreach for homeless and others. Often we're working in the schools. Typically a lot of the medical providers and primary care refer us, the clients, especially the ones that are more complex. Typically hospitals and emergency rooms use us as their primary referral entity as well as the Oregon State hospital and residential.
Again, this external locus of control results in several things. No shows. Individuals don't show up. People cancel their appointments sometimes what we would call lack of engagement or not clear engagement. And again, the clinician often feels less successful in those areas.

10 Minute Break

David Geels:
I did want to just point out to you know, these things we're talking about before the break around the engagement with clients versus in private practice settings and the external locus of control. And I think it's important to understand that once, even though here so we are, are certainly individuals who are not necessarily 100% here because they want to be on their own. And then on top of it, they basically are impacted by all of our enrollment requirements, our assessment requirements, our fidelity requirements as well. So you have folks that are tentatively in here and then they're impacted by a lot of our administrative requirements on top of it. And that does create problems sometimes for many individuals while in a private practice, sometimes people don't even recognize the administrative work that's going behind the scenes.
In this slide, I'm just pointing out that QMHPs working in these organizations don't operate independently. So that's really what this says is that QHPs have roles with the client in developing an assessment and treatment plan and directing QHA and peer services. But they have a 309, administrative supervisor. Often they're supervised by the medical provider, often they'll have a licensing supervisor as well and then they're impacted by their team environment as well. I would point out that this, these requirements, these kind of things only boost the cost as well, right? All these things just also further increase the cost of services for community mental health programs. The average day at work for somebody working within a CMHP, they're in their car allowing many of them out. Driving around travel time is significant.
Some clinicians spend 10 to 25% of their time traveling, especially in rural and frontier areas. And you know, if you combine that with a no-show rate of 25 to 30%, you can see that sometimes there's a lot of lost time in our work. A lot of the work is done in the community with employment providers, schools, courts, parole officers, social service agencies, and benefit organizations.
Here are some of the bottom-line things I think that are important. Some of them are kind of an assumption. I believe very strongly that currently there are not enough master's level clinicians to meet all the needs within the state. I mean, I think that's the bottom line. We just don't have enough workers to do the work and it's likely it's going to be that way for a good period of time. I can't imagine we're going to work through this within five years unless there's really a budget shortfall that creates a bunch of positions and things that go away.
Despite our efforts to try to recruit from out of state, we're going to continue to be short in this area. Given that we're going to be short, our opportunity, our options really is So what are we going to do about it? I suggest that we need to prioritize what we're going to do and what we're not going to do and we create mechanisms to prioritize our high level services, our key services over things that are not necessarily as

key. Currently what we are doing is we're incentivizing private practice and telehealth commissions. We pay them a very high rate. We pay them the same rate that we get paid to anybody else. And so that's kind of what our default position is. And you can see how the numbers are with organizations like Stronger Oregon and others. We really, our current system, we're incentivizing people to go into private practice and they are seeing the least needy individuals. So our current system is leaving behind those individuals that have the greater needs. And so if you look at the issues around inequities, this to me is a really a key thing that's occurred as a result of our actions. And so my suggestions are ways that how do we figure out how to correct the balance. So we begin to fill in the key vacancies within our community settings, community health programs, and other certified approved organizations.

And then here's a sort of a list of options. Some of these may have more weight than others. Some of them may be more easily implemented than others. But I did want to kind of put together a menu of possible options and these are a lot, a lot of them are related to payments. I think one option is to decrease rates for private practice group practice non-COA, non-CMHPE rates.

You know, I said to the OHA folks, you know, we need to sour the milk a little bit, right? I mean, the rates that we're paying now, which are often higher than commercial rates, you know, if we want to help people move back into the public health system, you know, I think changing the rate structure downwards might be helpful in that.

Now, the other converse option is to try to increase the rate structures for community mental health programs and CCOs. There are mechanisms in the current fee-for-service structure. There's what's called HK billing, and it pays a higher rate and it requires a pre-approval by the Oregon Health Authority, but it does pay a higher rate for certain types of services in certain types of settings.

However, I'm not sure that we could pay enough to CMHPS to really overcome the advantages of private practice by itself. So even if we were to pay higher, which the rates have increased for all mental health providers, I'm not sure that you could pay enough to overcome the costs related to administrative overhead, no-show rates, travel time, and other things. It would be difficult to overcome. We could also create an additional rate structure for services rendered out of the office. Currently, on the fee-for-service side, the payment, no matter what the setting, is identical, right? So if I go to somebody's house half an hour away and half an hour back and I do a service, I'm going to get paid the same as if I was paid in the office without the need to travel. We could create additional rates for team-based care. A lot of complex care is based in teams. Team-based care is more expensive, and currently, again, we base it only on the procedure codes. We could tie the rate to diagnostic or other complexity. Again, currently, the rate structure is not tied to complexity. If somebody is getting care for an adjustment disorder, that payment is the same as somebody who has schizophrenia or severe bipolar disorder. There's no differentiation in terms of the condition being treated.

The other option could be some kind of partial reimbursement for no-shows. A lot of community health programs do a lot of wheel-spinning to try to engage people without payment. I'm not sure that this would be allowed. This would require Medicaid approval, and I'm not sure how the federal government would feel about that, but it could be something that would be explored with the Medicaid folks at the Oregon Health Authority. Now, I do say just recognize that most of the payment here, though, does not come from the fee-for-service part. So most of the payments for mental health go through the CCOs. So some of these strategies for CCOs would have to be different. Most of them already have different kinds of arrangements, decapitated arrangements, some kind of value-based payment arrangements to deal with this. But some ideas in that area would be CCOs could potentially limit the panel size of their mental health providers. In non COA organizations they could not impanel new providers until the safety network providers were in place. They could do something around those things to ensure that the basic services are in place prior to expanding capacity in the non-emergent areas. There are also potentially areas where they could increase the utilization management and review the value of therapy provided by private practice clinicians. In many areas there have been no quality reviews. Now I know partly OH Medicaid changed its rules around parity requirements and made it more difficult, but at the end what we've done is given free rein and I think many people are seeing private practitioners for multiple years without really any review of whether those services are continuing to be valuable or helpful. I think we are in danger of creating a professional personal relationships out of private practice clinicians. If we're not careful, we

could also potentially require some brick or mortar presence availability within the community where clients live. I think the trend to really pay providers no matter where they live has some problems. There's no local routes for the providers and then the critical services are left to the communities in which the individuals live and the private practice person has no responsibility in those areas. The other sort of broad based approach could be it is no or reduced payment to associate clinicians outside of COA related settings, typically commercial insurance have not paid associate level staff at all, they've not approved those. That has changed some and I think partly it's some of the organizations that go do ACCO business and a private business have blurred the lines and they are starting to reimburse for associate staff. But it is something that CCOS could potentially do is to limit payments or reduce payments to those type of individuals. I would say also the CCOs might benefit from clear direction from OHA in any of these regards if we're going to look at a consistent approach through all CCOs. So again those are just some ideas around payment structures to help sort of balance things out. Like I said, I wanted to kind of present some information. I can tell you some of me, myself and several of my colleagues, we're sort of anxious to get some concrete ideas on the floor for you all to consider. I think we feel a sense of urgency because of our critical shortages in our workforce and an inability to stand up essential services like mobile crisis and app teams if something doesn't move quickly in this area.

Lindy Bonser: My concern would be the pushback that you would get from not only the private therapist but also that you know there are there are programs or practices in which mindful therapy group or the others, they're basically kind of like farming out therapists to create their own private practice. How would you address that?

David Geels: To me, if we believe that there's not enough providers to do all the work that is currently on people's plate, then no matter what we do, we're creating winners and losers to some degree, right. So I mean I think it really, it really is about trying to do this in a planful way. Right now the situation that we've done is we've created I think a lot of incentives for people to move into private practice settings to see the folks that are well off enough to get there on their own that have a clear, probably stated reasons about why they want to go there. And we've done that at the expense of other individuals that are probably more impacted and less able to do that. So if we do nothing that is the current situation. So I'm suggesting that we make purposeful decisions about what kind of care we're going to prioritize because I don't think we can do everything.

Jen Inman – Just underscoring that what we're sneaking up on is an unintended inequity in who gets care. The folks who are a little bit better, what we used to kind of refer to maybe as "The Walking Well," the folks that we thought would gain coverage when we expanded OHP. And what we found was that there are a lot of folks who are in really acute need who are not engaging in services without a lot of engagement and outreach. All of those other elements and the non-treatment related elements that CMHPS do in order to help folks get into care. And those are the folks that are now suffering because there aren't the workforce emergency and the movement of providers to these sort of slightly more stable scenarios even in the Medicaid covered population, those folks are getting more access. Everyone needs access, absolutely. But those are the folks that are getting access because of the way things have evolved. COVID on top of it, all of those other things. So I just want, I can appreciate how hard it is to make a recommendation that we move or reprioritize how access happens because we really are triaging. And what happens in day-to-day is that we're triaging who gets care because we don't have enough staff to care for everyone. And so it's already happening. And so there is an equity lens here that is an unintended population health issue that's happening because we don't have a service. The other piece of that is that, and I really appreciated David's comparison of why would I do that when I could do this is that what we created is all the things that we know about what supports well-being at work are all of the things that we are unable to provide in the CMHP version versus the private practice space. Autonomy, flexibility, control of my day, all of these elements actually being able to see progress in my clients versus needing to identify that progress only means these tiny little spaces that we're able to move because of the models of care that we're providing the CMHP world. Just wanted to underscore those pieces that it's very, very difficult to talk about policy recommendations where there could be losers to move, just move the exact same resources around to different populations, especially the population that has very little voice in this process.

Diane Benavides Wille – I was going to bring up the issue around equity and I know that it probably might feel a take away with a recommendation to reduce or take a look at rates depending on where you are conducting your services. But what I would say is an equity has in fact been created from that client program, participant, consumer perspective in that as a community mental Health Organization, we do in fact see everybody that walks through our door. And what has happened with the smaller private practices group practices much like was highlighted in the presentation is they are typically seeing clients at that level A. So what is trickled down to community mental health organizations is more acuity, more services that are needed. And so from a clinician standpoint, having that balance of I've got a good mix of level AS and level BS and I might have a level C that's waiting for a higher levels of whatever it might be. We aren't seeing that. We are seeing level BS, level CS, level DS trying to be managed in a community mental Health Organization. While private practices tend to take clients that fit into this nice niche and it creates another burden on the system where we don't have enough staff to be able to meet that need. And the acuity that we are seeing without also the same administrative burden and all the other things that David talked about in terms of the regulations, they aren't worried because they're not on case rates. So they're not worried about a risk corridor or utilization reviews or all of those other things. So there is a big impact to what has been what has happened as a result of COVID and the workforce and sort of the perfect storm where all those conditions kind of ran into each other.

Melinda Del Rio – I appreciated the PowerPoint. It was very informative in a lot of different ways and just like hitting a lot of key points. I think overall there's a shortage of the workforce in general regardless if like with even like the private practices as well too. Like those are from what I've heard around different areas of like those are full and also like that whole flexibility piece too of like what how many how many people are being seen by a clinician and so many other factors. But like the recommendations of like, you know, for people who are traveling, like being paid for that traveling time being like some sort of payment, whether it's like a grant for like the amount of no shows. Because you can't charge cancel like late fees or cancellation fees or whatever towards Medicaid clients. But that's a huge financial burden for any COA or CMHP like because it's like how do you continue to sustain the revenue? And then also like increasing the wages, not just like I would say on all levels, like when I even look at the job postings for nonprofits and it's like the salaries are horrible even for supervisors and director, it's just like and with today's economy, like things are just so expensive. It's just not a livable wage, even with the recent upgrades that have happened or like financial updates that have happened for the fee for service and everything. So I think just higher salaries across the board. I think one thing to consider too depending on the program is like kind of getting creative with schedules and scheduling of like is it a complete in-person role. If it is like having more, I don't know perks of like being like loan reimbursement, you know financial assistance in different areas when it comes to student loans. Because sure I don't know, I know I still have them. I don't know how many of you can still have to, but like, it's a lot. It's so much money. And with all of it combined, it's like to really make and even playing field. It's like I think instead of trying to take away so much or maybe there's like a balance of it. I think there's also a piece to give into all these different programs and the staff as well.

Jen Inman – I thought on the impact of, you know, even if everyone were paid way more, you still have a disparity of what the work feels like, which is obvious to all of us, you know, and David's graphic really demonstrated that. So let's just say for a moment that everybody was getting paid enough. Now, what do we do with the other aspect of this, of those other pieces? I mean, everybody isn't being paid enough. But this, the other topic is, what's the job feel like? How much control do I have? How much autonomy do I have? How much flexibility do I have? How much time am I spending to all these other pieces? So there's that piece that we need to really think about. What policy decisions are we making with respect to fidelity models, requirements, oversight? What does it look like in a COA/CMHP compared to a private? What are all those other elements that we could tackle as well?

And the second piece is and this has come up for us recently as we think through the care that we provide via in person versus Tele. When you have a provider that provides exclusively telehealth care, how are they assuring that their client is actually being served in the method that's clinically appropriate for them and that they choose? Are we actually looking at that when we have had the experience of having a provider that was exclusive, exclusive Tele, they there was an unintended bias to asking the question

about whether or not that preference was for telehealth care in a way that reinforced the provider's preference to provide the service. Tele and that provider couldn't provide service in person and so a change would mean a change in provider. You can't opt out of being a Medicare provider to be a Medicaid provider, but you can opt out of providing services in person to be a Tele provider. And how does that work when your client is dependent on you and is going to say yes to you? And how are you assessing whether that's clinically appropriate when you're not doing a status exam or seeing your person in person, especially folks who have higher acuity? And so we noticed that we were generating yeses to telehealth service when that may not have been in the best, the best clinical interest of that client, but it was in the best work and interest of the provider even though that's not what they intended. Our clients say yes to us. So what around review or oversight around telehealth is really happening in terms of is that OK and what do full tele providers whether they're in the public space, private space, whatever, what are they doing to assure that the service being provided is the appropriate type of service. And I don't mean that the person has to come to your office. I mean we may go to the people and that's what we do now we go out to the community to do that assessment. And we found that we get different results when we see clients in person at least occasionally, at least the clients that we're serving. This is, I don't want to give up telehealth services which is absolutely an improvement for many clients on many occasions. That's not what I'm suggesting, but to make it an exclusive option for folks and it's the only option. And then we reinforce that because we don't have an alternative to go see the client or to have the client seen in person as a policy decision we've made with a potential inadvertent outcome that's not the best quality for services may not even be safe.

Cheryl Cohen – Yeah, David, I really, really appreciate the presentation. I thought it was really thorough and really echoes a lot of what I've heard from providers throughout the state around the current system really financially incentivizing clinicians to leave CMHP and COA organizations to go into private practice. And I appreciate what you said around making purposeful decisions. I think the feedback I've heard a lot from CMHP and COA providers is really about being purposeful. So before you know, before doing something like implementing, I think a good example is the implementation of the 30% across the board rate increase. I think if you know, did we need a rate increase? Yes. But we needed something with some nuance. And I think before we're doing something, you know, thinking about being purposeful. So thinking about you know, before something like a 30% rate increase that went everywhere asking kind of how will this impact the workforce. So it, you know, is this making people leave, workers leave CMHP&COA organizations to go into private practice at higher rates cause we have seen as a COA lot more people leave those settings to apply to our panel to leave and go into private practice. And also to ask you know before doing something, how will this impact access and for who like Jen was saying, so if therapists are you know moving into private practice and they're primarily serving higher functioning clients and therefore we can't serve acute people who need an ACT program anymore, who is our system really increasing access for? So I just, I really appreciate the presentation and some of the recommendations that were made.

Anthony Cordaro – Second, what a lot of people, everybody has kind of been saying David and really appreciate the educational talk today. And you know I have a lot of things kind of percolating through my mind. But one of the things, you know, a lot of stuff about Tele mental health, Tele healthcare in general, I think has really rocking or changing the landscape of healthcare across everything, but there's also benefits. And I think we just need to be mindful of some benefits like actually it allows people better access. They have to have Internet access. And there's maybe some equality issues with that, but they don't have to come in. They don't have to leave work, they don't have to get up. You know, as somebody who treats kids, you know, you're not disrupting school time, etcetera, for them to physically get to my office. The other thing is, you know that I've seen it improved access to highly trained providers, so getting a specific therapist who knows a specific skill set that somebody really needs, like getting somebody in who has OCD into a therapist who actually knows ERP treatment, you know, can make a difference, or access to a child psychiatrist. And so I think we need to, I'm not saying I have any solutions, but there are benefits to telehealth and definitely there's a lot of issues and a lot of the stuff that Y'all brought up particularly, agencies, organizations that work outside of our state, sending job offers to people here and stuff like that. And what that does for providing care, not even in our state, but providing care to somebody

in Florida, is definitely an issue. There's a ton of issues with it. But I just wanted to add that that it could actually learn some good things and particularly providing access to highly skilled providers, I think is one as a way to solve the fact that there's not, you know, there. There's a lack of that. I mean, in fact, that's the whole reason we're kind of talking is there's just not enough providers.
Melinda Del Rio – I had another thought that just kind of came into my mind. And so as I'm kind of hearing all the different things and one thing, it's like one thing I was thinking was like because we are seeing a shift of private practicing, lower level of care and you know, community mental health and COA as kind of having a higher level of care. Like, I'm curious of just if or what kind of discussion there could be around the pay differential based off of the level of care and the level of care that's received, cause I know there's also a lot of clients who they need a higher level of care, but they just refuse to or there just isn't enough room or access. But I'm curious about that or like that possibility too and kind of helping the revenue as far as the COA, CMHPS and nonprofits and everything, and then like the telehealth versus the non telehealth, I think that would also factor into like that level of care factor. So, yeah, a lot of different ideas, I think, with travelling and based on complexity. But I was like hesitant to use that because there are pretty complex clients, but they're not actually receiving the level of care they should be, whether it's like room or because they just don't want to.
Kelli Bosak – I saw Shyra's hand up previously, do you have something you want to say, Shyra?
Shyra Merila – Maybe I just, you know, I just and this is obvious, right. But in our medical model, it's not uncommon for providers who serve like more acute, more complex patients to be paid more and community mental health programs. We're specialty care, we're specialty care and we serve the most acute in our communities. And so I think that as soon as we started talking about this in a way of like there's a pie and there's only so much of this resource. And if we take away from private practice clinicians, then people start getting a little defensive like whoa, whoa, their work is important too, and then becomes a scarcity kind of conversation. And I don't think that's the direction we need to go. I think like just acknowledging what it is. Communal health programs provide specialty care for acute populations, and there are plenty of other spaces in our medical system where providers are paid more and compensated differently for that level of work. And we need to start talking about our community mental health programs like in this sort of more, for lack of better word, like prestigious kind of way. Like it takes a crap ton of training and support and money and systems and all of the things in order to serve the communities that we serve. And we need to recruit people sort of in in that way with that mindset and think change the way that we even talk about community mental health programs. So I just wanted to shift our attention from like a scarcity. There's only so much of the pie we're going to take away from private practice clinicians and just get back to acknowledging what community mental health programs are doing and what it means to support them in meaningful ways. Thanks for prompting me, Kelli.
Kelli Bosak - Thank you. That was incredible. I'm glad that we made space for your comment too and I absolutely echo a very well said and I really appreciate David's presentation. I learned a lot too and kind of I had similar thoughts as Shyra around, you know as in as somebody who has worked in community health settings, so primary care, FQHCS, safety net in different States and coming to Oregon the CMHP system was new to me, that did not exist in Illinois. It was defunded and closed. I'm provided this level of support in the continuum of care. And I absolutely agree that if it is not well funded and a well staffed and staffed with these really quality people, everyone suffers on the whole continuum and every provider at every level. So I love highlighting and really kind of really changing the narrative around CMHPS and the kind of thinking about how do we kind of kind of allow all boats to rise together. So and especially in terms of the regulation around what you were describing with COA and CMHPS all the laws and rules that have to be followed. How can we kind of increase some of the accountability of really private practice systems that are really just accountable to billing and a little bit of compliance through who they bill and this and some other laws versus the CMHP that is spending. Some people are dedicated to their entire days and jobs following these rules and guidelines. So how can we ease and then increase a little bit to balance it. And I would be really grateful to hear from those who've been working in the CMHPS to say what can you see changed and some of those rules are improved, just that we can issue some recommendations around and support for you all.

Jenn Inman – I really appreciate Shyra, thank you for the reframe. And it made me think what we're talking about is two different kinds of service delivery. CMHP work is population health. It is not fee for service treatment and counter based care and the solutions we need, need to reflect that. So the policy decisions we need are population health policy decisions, not how do we change a fee for service and counter based fee structure to solve the situation. Too much of the work or too much of the cost or too much of the burden or the reason why doesn't have to do with that. And if we keep trying to like just focus on the cost per service, we're going to miss the mark. It costs more per service hour in a CMHP model that's providing a fidelity service for all the reasons David laid out. And that dollar is those that rate is not getting to the provider like it doesn't practice in private practice in a more direct way. And so maybe it's our framework for thinking about it will help us guide some policy conversations about how to address it. We need to be thinking about population health strategies, team-based care systems care not a fee for service strategy or a very specific piece. So I really appreciate Shyra and Kelli's comments to try to move us there because I absolutely agree. I don't want to lose any access in that middle space that we have lost CMHP care for too. We need it there. We need the providers in the schools. We need the providers in the primary care. We need the providers everywhere that the people are and they're also on the street and that's where the CMHPS are and we need to make sure that we have providers that can serve them.

Tim Nesbitt – Wrap up

Record of Vote
Topic: Meeting Minutes Approval 4/17 and 5/1
Outcome: Both meeting minutes approved

Y	N	Abstain	Absent	
☐	☐	☐	☒	Belindy Bonser
☒	☐	☐	☐	Kelli Bosak
☒	☐	☐	☐	Chris Bouneff
☒	☐	☐	☐	Cheryl Cohen
☐	☐	☐	☒	Sarah Conyers
☒	☐	☐	☐	Deanna Cor
☐	☐	☐	☒	Anthony R. Cordaro, Jr.
☐	☐	☐	☒	Lorie DeCarvalho
☒	☐	☐	☐	Melinda Del Rio
☐	☐	☐	☒	Jose Luis Garcia

Y	N	Abstain	Absent	
☒	☐	☐	☐	David Geels
☐	☐	☐	☒	Qurynn Hale
☒	☐	☐	☐	Clark J Hazel
☒	☐	☐	☐	Jenn Inman
☒	☐	☐	☐	Tony Lai
☐	☐	☐	☒	Lucia Mendoza-Meraz
☒	☐	☐	☐	Shyra Merila
☒	☐	☐	☐	Tara Sanderson
☐	☐	☐	☒	Sheri Selander
☐	☐	☐	☒	Mario Cardenas
☒	☐	☐	☐	Diane Benavides Wille