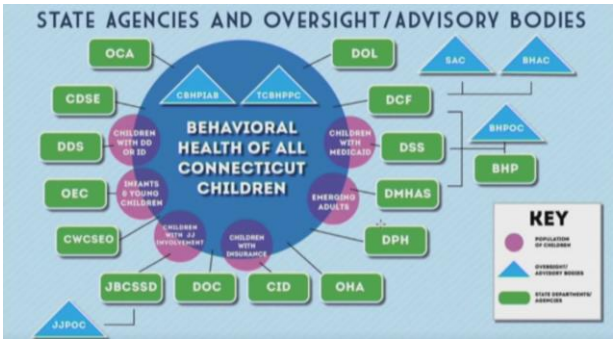
Children's Behavioral Health Plan Implementation Advisory Board
June 17, 2024 Meeting Minutes

1. Welcome

Tri-chair, Carl Schiessl, opened the meeting with providing the background on the Children's Behavioral Health Plan Implementation Advisory Board (CBHPIAB), which was created through CT General Statute. It was organized in the wake of the Newtown tragedy. Connecticut enacted a Children's Behavioral Health Plan – communities, providers of care, families, agencies, policymakers all united in an effort to respond to the tragedy.

Schiessl introduced the diagram of State Agencies and Oversight/Advisory Bodies (see below). This diagram can be accessed in the Annual Report from October of 2023, and there is a more detailed description there - www.plan4children.org.



The blue triangles represent Advisory Bodies. The CBHPIAB is one of the triangles within the big blue circle, which means this board touches all children's behavioral health work within the state. The other blue triangle is the TCBHPPC (or TCB) whom we work closely with. The JJPOC, the SAC, the BHAC have recently presented to this group, and BHPOC will present at today's meeting.

The CBHPIAB has been inviting representatives from the other advisory bodies to come and talk to us about what they're working on and what their priorities are. This information will be aggregated and consolidated in our annual report. This diagram is intended to help illustrate the complexity of CT's BH system and its advisory bodies, but also the complexity of the different sub-groups of the children's BH population. We want to be responsive to all of CT's children's BH needs.

We are here to go to the next level of conversation and input about how we can improve the successes that we do have in the children's BH system, as well as identify the areas that we might want to focus our attention going forward.

The Tri-chairs reorganized the agenda to address a timing issue.

2. Workforce Strategic Plan Updates and Discussion

Aleece Kelly, Child Health and Development Institute (CHDI), presented an update on the Workforce Strategic Plan (*Strengthening the Behavioral Health Workforce for Children, Youth, and Families: A Strategic Plan for Connecticut*). In October 2023 the CBHPIAB approved the plan as a collaboration with the CBHPIAB. Kelly provided an overview of the plan. CHDI was funded by DCF to develop a strategic

plan for the state, specifically for the children's BH workforce, looking at the workforce pipeline, recruitment, retention, diversity, and competencies of the workforce.

Dr. Michael Hoge, Yale/Annapolis Behavioral Health Workforce Center, was a co-author and provided consultation, and a small Advisory Group composed of stakeholders, including providers, family advocates, higher education, and multiple members of this advisory body provided guidance on the process and recommendations. The process included a widely distributed stakeholder survey, a review of national and out-of-state best practices and innovative models, an inventory of CT efforts, and key informant interviews.

Kelly presented the recommendations from the Workforce Strategic Plan and the progress made during the 2024 legislative session (listed below). Kelly welcomed feedback to any progress missed, and discussion on next steps:

1. Increase reimbursement rates for children's behavioral health services to cover actual costs of high-quality care and establish a transparent and systematic rate setting process.
    - Allocation of $7m for children's behavioral health
    - Medicaid rate established for UCC services
    - Legislation to support reimbursement rates for telehealth
2. Make immediate and significant investments in behavioral health workforce recruitment and retention
    - No progress noted
3. Develop a children's behavioral health workforce that can track and respond to trends in supply and demand and sustain workforce development efforts
    - No progress noted
4. Grow and diversify the children's BH workforce pipeline
    - CT Health Horizons: initiative funded before this workplan was launched, but has rolled out further this year
    - New student Loan Repayment Program
5. Increase BH training across the child-serving workforce
    - There are great training opportunities in the state, but there gaps identified through the strategic plan that have not been addressed this year
6. Remove administrative barriers to workforce entry and retention
    - Policy change (PA 24-30): participation in multi-state social work licensure compact
7. Expand the youth and family peer support workforce
    - No progress at the child level, but some legislation for adult services
8. Expand the role and capacity of community-based organizations in prevention and early intervention
    - Not something that was a focus over this last legislative session.

Kelly asked the CBHPIAB Members: Is there any additional progress on recommendations that wasn't captured? What recommendations should be prioritized in FY25? What is the role of the CBHPIAB and individual members in making further progress on recommendations? No comments were made by the members.

3. Behavioral Health Implementation FY25 Priorities

The Tri-chairs introduced the next item, stating that one of the areas the CBHPIAB is looking for additional guidance around is building off the successes and findings that came from the workforce strategic plan. The CBHPIAB is interested in hearing how might we continue to build the workforce piece? How can peer workforce development be included? As the CBHPIAB looks at the areas for focus, there are areas needing input from our members – one of them is the peer workforce. The CBHPIAB would like to seek information around the role of parents and peers. The SAC and CBHAC have both presented to the CBHPIAB. They had a very robust level of participation by their family partners. What should be the focus in relation to peer workforce and peer system involvement and promoted voice).

Members responded positively to the idea of a focus on the peer support workforce. Comments included: Much appreciate and welcome the desire to have more of a parent and family voice. This is integral to the work that we do, to have them at the table as things are being operationalized, as opposed to planning and then them being told what is done. DCF would support the work of expanding the roles of peers in the BH system. We have several programs where there is involvement of people with lived experience, and the services are better for it, and the service recipients are better for it. One of the opportunities would be to see where do we have systems and infrastructure that support that, and where do we need to build and enhance the infrastructure to support that? In the adult service system, there have been several initiatives for developing credentialling – we could learn from the adult system. On the federal level, SAMHSA has been a proponent of facilitating this involvement and has funded several initiatives – CT can build on their work.

One of the key components of a strong peer support program is structure and support for peers. How do we make sure we are paying attention to the level of support that peers might need to work with families? The sustainability of the work and the workforce is dependent on the support they have through their work. How do we build that into any new system we create and make it accessible?

We've seen the benefit of peer support specialists and family peer specialists and the work they do. Ensuring there is a career pathway for the people in these positions, to see there is a place for them to continue to grow and develop.

We are seeing that both areas of the workforce are critical for attention. We need to do further study of best practices: where are there strong models? What are reimbursement models, what are training models, what are support models, that we can build upon in CT? In addition to tremendous shortages at every level of care, what are the opportunities to promote the professional workforce, and build upon the other resources we have to support children and families?

4. Child/Adolescent Quality, Access, and Policy Committee of the Behavioral Health Partnership Oversight Council

Presentation by CAQAP Chairs, Dr. Steve Girelli and Melissa Green

Dr. Girelli began the presentation with an overview of the CT Behavioral Health Partnership. It was created by the Legislature in 2006 to improve access and quality of Medicaid-funded behavioral health services in CT. Originally the partners were DCF and DSS, DMHAS was added to the partnership in 2010. The goals of the partnership are to:

- Improve the quality of BH care (mental health, substance abuse, and support services) especially through the oversight of Medicaid services and expenditures
- Promote prevention and recovery by working with individuals, family members, providers, and other local social support programs
- Attend to the cultural needs, strengths, and preferences of members and their families.
- Make the best use of federal and state funding.

The legislature then formed the CT BHPOC as a way of making sure that the CTBHP lives up to legislative expectations. Designated consumers and consumer family members are appointed by a legislative process to sit on the Oversight Council. There are seats on the council that are appointments by a number of legislatures, governor's office, etc; and there are seats on the council especially designated for consumers. All consumers and consumer family members are encouraged and welcomed to participate in the Oversight Council committees. There are 36 members, each appointed by a partner state agency, legislator, or the Governor. Of those 36, six seats are designated for appointed consumers or consumer family members

In addition to the three partner state agencies that attend and present at BHPOC meetings, other state entities also participate, such as the Department of Developmental Services, State Dept of Education, and the Court Support Services Division of the Judicial Branch. These state agencies sometimes present in official reporting capacity, and sometimes less formally. There are three chair persons and they consist of a consumer or family (currently recruiting), a provider or advocacy representative, and a member of the CT General Assembly.

The BHPOC Committee Structure includes four committees: Operations; Child/Adolescent Quality, Access, and Policy; Adult Quality, Access and Policy; and Coordination of Care/Consumer Access. There is one more that we will reference later. Most of the work of the Oversight Council is performed in its committees. Committees meet on a regular basis (schedules posted on BHPOC website & announced at each meeting). Participation in the committees is open to the public and includes consumers, providers, state agency representatives, and other stakeholders. While there is a group of attendees that regularly attend the committee meetings, there is no official membership list as anyone from the public is welcome to attend and participate. Attendance and participation have increased since the meetings became virtual, and thus more accessible. Committees report on meeting content back to the Oversight Council and make recommendations to the Council about improvements in quality and access in Children's behavioral health. The Council will occasionally request action by a certain committee.

The Child/Adolescent Quality, Access, and Policy Committee Purpose is to bring together family members, advocates, providers, state agencies, and other partners to maximize the impact of children's BH services and supports funded by Medicaid and other grant funded services. All of these participants might be impacted by or impact the delivery of Medicaid BH services to children in the state of CT. Technically other grant funded services are outside of the mandate, but they are so enmeshed with Medicaid at times that it's not always possible to draw a firm boundary between the two, especially when you're looking at the continuum of care.

The CAQAP identifies and addresses key issues of concern to consumers and providers to enhance quality and access. This is why involvement from consumers is so critical. It reviews data on the effectiveness of the initiatives, policies, and services of the BH system. We rely heavily on data and

reports from Carelon, and Carelon is very responsive to our committee's requests for data, but there are areas that the data does not reach. DCF is also a big source of data, especially on areas that Carelon may not be collecting data on. The data addresses the needs, strengths, and gaps in the BH service system and make recommendations to the Council for improvements. The focus is primarily on identifying gaps. We don't ignore strengths, but our focus is often on what problems/gaps exist in the system, and how we can fix/fill them. The CAQAP provides input to the State's plan for federal health care reform and other emerging mental health policy and program developments.

The Child/Adolescent Quality, Access, and Policy Committee meetings involve one or two presentations about Children's BH services in CT (e.g. data about the use of emergency departments for BH needs, use of Emergency Crisis Intervention Services, outpatient clinics' responses to the Covid pandemic). In addition to these topics, each meeting includes an update about the work of the CFAC. Determined in advance, and an agenda is put out to our distribution list. In every presentation and discussion, we try to address equity in the BH system.

The Child/Adolescent Quality, Access, and Policy Committee key topics have included:

- Utilization of Emergency Department and in-patient psychiatric beds ("stuckness" factors) (this topic is focal for most of us for the last couple of years, and we have a quarterly report from Carelon on this data). CAQAP has been tracking these data from Carelon. Generally, there has been some improvement at times, though with no dramatic decrease in utilization. CAQAP monitors factors that may impact utilization at the high end. (Availability/utilization of intermediate levels of care, Availability/utilization of step downs from these levels of care, Reasons for admission/readmission).
- Introduction of UCCs and impact on ED and inpatient utilization, as well as a review of transition from ARPA funding to Medicaid reimbursement.
- Utilization/availability of intermediate levels of care, esp. as regards their impact on ED/inpatient utilization.
- UCC utilization and effectiveness, as well as funding under Medicaid. This is a brand new model rolled out a few months ago. There is a marketing need for these UCCs – if the person bringing the child to an emergency department doesn't know about the existence of the UCCs, they will still bring them to the emergency department.
- Non-Emergency medical transportation and its impact on access to care. Not discussed a lot in the Child/Adolescent committee, but discussed a lot under other committees, but we are going to start looking at it more, due to its relevance to health equity. Key concerns have included:
    - Reliability of transportation (no-show rates, wait times)
    - Limitations on use (transportation of siblings to appointments when childcare may be a challenge)
- Medicaid reimbursement levels for ambulatory BH services and state response to national study revealing inadequacy of current funding. Remediation plan details and timeline. Provider input opportunities.
- Health equity within all of these broader topics.
- Funding Adequacy
    - Phase One (of Two) of legislatively mandated Medicaid funding study established significant underfunding in CT relative to states deemed otherwise comparable.

- Reimbursement levels for ambulatory BH services were among those deemed significantly inadequate.
- DSS and other state agencies are discussion remediation efforts and funds
- Some concern among non-profit providers that increased funding will prioritize private practice reimbursement, ignoring great costs of funding nonprofit services and their critical role in CT's BH
- All BHPOC committees, as well as BHPOC itself, are reviewing state plans as they develop to evaluate their likelihood of adequately addressing the shortfall.
- These are seen as critical opportunities for consumer and provider input.

Child/Adolescent Quality, Access, and Policy Committee Heath Equity. The BHPOC and all of its committees have for several years focused on health equity. Within committee reports this has taken two forms with regard to presentations: The first has been presentation specifically about health equity, disparities, and contributing factors. The second and more common approach has been to embed within reports on other topics data regarding equity, access, and utilization. BHPOC also created a DEI Committee that is focused on health equity. One of its most significant accomplishments was to recommend to the BHPOC that it request of DSS lifting the suspension on the new ECCs in order to dramatically increase accessibility, which DSS has done.

Dr. Girelli opened the topic up to the CBHPIAB for questions and comments.

5. Member Updates

- The study that CHDI is doing regarding school-based behavioral health services is part of the state's investment in the Project AWARE grant program. Using American Rescue plan dollars to continue that work. Pilots that are still ongoing and might request an opportunity to bring those districts to the CBHPIAB to talk about their experiences.
- State Department of Education (SDE) has a summer BH grant program that we are finishing the analysis of those school districts that have applied for that grant funding, which we can announce the recipients of in the next few weeks.
- DCF wants to underscore some services that are available to families as we are going into the summer, when the schools are closed and cannot provide their usual support:
  - Collaboration with United Way on implementing 211 and 988 as crisis service lines which result in mobile crisis response, as well as 211 as a resource for families looking for more information on BH care.
  - The UCCs that are opening and doing great work in Hartford at The Village, in Waterbury at Wellmore, in New London at Child and Family Agency of Southeast CT.
  - Family Assistance and Social Determinants funds available – management of those is managed by Carelon. These funds are for families who don't otherwise have the means to access care through insurance or other means. fasd@carelon.com
  - connectingtocarect.org remains a central place for accessing services and supports.
  - Family First: Brief Strategic Family Therapy and Parent-Child Interactional Therapy are being incorporated as part of our overall Family First community services prevention and supports – contracts are in negotiation.
- CT Dept of Public Health: we are finalizing the funding we had available – $9m for school-based health centers with a focus on mental & behavioral health services. Applications will be put in for

school-based health centers, which would include medical, mental health, and dental. Contracts should be signed within the next couple weeks and will last for the next two school years. We are also getting ready to wrap up some of our data on the school-based health centers.

Closing

- The Tri-chairs closed the meeting and announced the next meeting date (July 29th). *[The July 29th meeting was subsequently cancelled].*