Facilitated Discussion Notes
Coordination of Care and Integration of Care
April 23, 2014

Below are notes distilling the comments made by participants during a Facilitated Discussion of this topic. Generally, the comments are listed in the order in which they occurred. Redundancy with respect to comments has not been eliminated. This information will be combined with input from other sources and will inform development of Connecticut's Children's Behavioral Health Plan. If you have comments about these notes, please email project staff at: info@plan4children.org.

General Notes

- Hosted by Coordination of Care and Consumer Access Subcommittees of the Behavioral Health Partnership Oversight Council
- Location: CT Legislative Office Building Room 1E
- 19 people in attendance

Question 1: Strengths

- Engagement of families and consumers is a strength in CT
    - Lot of programs and resources for families
    - Strong family participation across state
    - Information about programs and services are shared between families
    - Subcommittees (such as Consumer Access and Coordination of Care) allow consumers to share what's working
    - Training at grassroots level to include family participation across systems tables
    - State sees value of incorporating input from youth into the plan
- Existing services and programs in the state
    - Increasing numbers of services/ intervention programs recognize the complexity of needs faced by youth and families and do have identified roles for care coordinators, patient navigators, and/or peer and family peer specialists and provide access to care coordination to reduce barriers
    - Increase of Patient Centered Medical Homes bodes well for expanding coordination of care
    - Department of Public Health (DPH) programs provide care coordination at state, regional, local levels to share information around shared cases
        - Medical home initiative care coordinators are very successful in helping families navigate the complexities of the system
        - DPH School-based health centers
        - Community health centers also help to meet the needs
    - Home visitation and accompaniment to specialty clinics and PPT meetings is a strength
    - Some programs monitor to ensure that families receive the offered/referred resources
    - Wide array of children's behavioral health services available in the state, including acute care, home-based, and ambulatory with ongoing communication across service providers and ValueOptions (state Administrative Service Organization):
        - Pediatric acute services: spend considerable time in discharge/transition planning when child is leaving the hospital through Value Options (ASO) to increase likelihood that child is connected to next level of care. Positive, stable relationship and clear communication between hospitals and ValueOptions, rare denial of services.

        - Sub-acute and psychiatric residential: longer length of stay, but goal remains successful disposition and transition to community in an appropriate manner
        - Intensive outpatient and evidence-based, intensive in-home based services: goal is ensuring medical necessity and appropriate length of time
- Administrative Service Organization (ASO) model is strength in CT over previous Managed Care (HMO) model
    - Rich data system that allows us to be data-driven compared to other states
    - Extremely beneficial to patients to have single ASO to navigate the system for providers
- State is paying attention to trauma-based therapy and making it available
- Recognition of consumer input and coordination of care across health systems within public Medicaid system is reflected in this committee (Coordination of Care and Consumer Access subcommittees of the Partnership)
    - Includes coordination of services of Department of Social Services across systems to benefit individuals and families

<u>Question 2: Concerns</u>

- Input is not being gathered directly from children (e.g., those in residential care, juvenile justice settings) who are actually receiving care coordination services to understand their needs and how to better serve them
    - Strategy: two facilitated discussions have been held at Solnit North and South to obtain input from youth
- Pediatricians are often unwilling to provide services for children with special needs, which may result in lack of services for families trying to access them; driven by the doctor's preference and what they are comfortable addressing
    - Strategy: Intensive Care Managers (ICMs) are available through CTBHP to help navigate system and have received positive feedback
    - Universal screening is not done consistently across practices and those that are done are not integrated into medical health records, which limits interest of providers; capacity in community is low to meet special needs once identified through screening; early screening and intervention is needed along entire continuum to have a greater impact
    - Need additional training of providers outside of their comfort zones/specialties with respect to service delivery to meet the needs effectively
    - Things happen in the system that create stress for families; more should be done to treat people humanely to reduce frustration
    - Strategy: more funding needed to support "warm hand-off" between and within systems to support care coordination; billing codes to support time needed to coordinate care; parity for commercially-insured; transition-aged youth need additional supports to prevent getting lost in the system; important to think creatively to provide supports (e.g., peer specialists for youth transitioning out of DCF care, and perhaps into DMHAS adult system)
- Need to do better at breaking down silos and think holistically, "We need to do better at looking at one-stop shops" to help the state save money and the child to do better in the long-run
    - Information is not shared consistently across providers—e.g., school nurses are not aware of medication needs
    - "Need to decrease redundancies in efforts and increase positive outcomes"
    - Reimbursement/policies for time related to care coordination and information-sharing activities for providers are restrictive or non-existent

  - Barriers to communication across systems by state regulations on privacy and confidentiality; "State laws impose greater constraints than does HIPAA"
  - Need to go beyond medical needs to assess broader stress and challenges faced by children/families; where there is recognition, there is not enough programming or resources
- Multiple demands are placed on families served by the Department of Children and Families to do so much within a short period of time without making sure basic needs are first met for families
- In-home services need to be adapted on an individual basis for families who need different services or providers (e.g., a family may need more than 6 sessions for an evidence-based treatment)
- Reduced Department of Public Health budget (due to legislative cuts) will have impact statewide on care coordination for children with special health care needs next year to result in reduced staff and reduced care coordination services for families
- State database outdated, doesn't allow for sharing outcomes or information beyond demographics
- Lack of access to care for children with commercial insurance compared to those on HUSKY, particularly for in-home services. Coordination of care is predicated on health insurance coverage, so goals for coordination of care will not be realized without enrollment. Explore parity legislatively.
- Lack of non-English speaking providers is a growing concern.
- Family voice not taken into consideration or acknowledged as it should be, although families are increasingly engaged across systems
- Lack of mental health providers

<u>Question 3: Recommendations</u>

- Need alignment across systems to facilitate service access
  - Align ages for transitions across state agencies to avoid gaps, frustration, and lack of payment (e.g., child may be receiving DCF services, but have a need for another agency's services and be rendered ineligible due to age restrictions even if they otherwise qualify)
  - Allow multiple family members to receive same services as needed
- Workforce needs training to be knowledgeable about all care coordination services for all mental health and medical providers that work with children, perhaps through DCF Training Academy
- Data/medical records/information sharing:
  - Coordination of electronic medical records across all child-serving settings, needs to be compatible, encrypted; The Health Information Technology Exchange Connecticut (HITEC) may serve as a resource
  - Patient registry to be implemented on universal basis across all pediatric and family primary care practices to ensure tracking of patient information for children with behavioral health needs—CT Chapter of American Academy of Pediatrics and the CT Academy of Family Physicians, together with the Health Information Technology Exchange may be able to assist
  - All agencies need to have policies requiring information sharing across virtual treatment / interagency teams
  - Statewide policy is needed regarding confidentiality laws and information sharing--CT Psychological Association may be resource in this process
  - Need database for outcomes with funding for staff to manage database; stop re-creating the wheel and use existing data to drive decision-making
- Time for care coordination must be reimbursed under current fee-for-service system; "these activities should be considered as a necessary component of care in a bundled fee arrangement"
- Care coordination to be provided to all children who need it across all ages and all areas of need
- More cross-collaboration across existing care coordination programs and cross-training across systems, with full funding, in a manner that incorporates grass-roots and faith-based providers

- Multidisciplinary care collaboratives are being developed
- Cultural sensitivity beyond ethnicity is needed
- Utilize parents and family members to help coordinate services alongside care coordinators and employ them as full partners
- Needs active involvement of Department of Children and Families, Department of Social Services, Department of Public Health, Department of Education; and also faith-based organizations
- Need monitors in schools to make sure children receiving services receive proper advocacy
- CT is at forefront of integrating dental and physical health. Dental health should be emphasized as it relates to overall development and is often overlooked.
    - Oral health program should be integrated into every school
- Promote continuous eligibility of our public insurance coverage programs through legislation
- DCF services should treat family as whole system, not just identified child; should be state mandated to provide family-based services to whole family
- Early mental health screening and detection to be supported and increased through education of pediatric primary care providers on how to screen, billing mechanisms, funding supports, and referral processes across children's and adult (parent) services
- Enhanced funding for prevention is needed through in-home intensive supports (e.g., new mother falls apart 3 days after discharge from hospital) through home visitors
- Pediatricians are not equipped to help with all systemic issues (e.g., job loss, loss of primary caregiver) that families face

General Participant Comments

- Funding cuts for next fiscal year at Department of Public Health are across the board and will trickle down to families
- Prevention needs to be increased:
    - Increase prevention by moving "all the way upstream" to pregnant mothers
    - Need Return on Investment strategy to sell need for enhanced home-based and preventative services by making the case for what happens if services are not provided. That would be a lot of work, but worth it
    - State is "spot on" with coordination of care and integration of behavioral health and primary care as strategies to strengthen children's behavioral health system
- Challenge is "taking all of this rich conversation and putting it into the plan but making that plan real and alive"—roll out to share with families, communities, and agencies so the efforts can be realized and will continue conversation post plan-development
- Before making recommendations—build on existing resources
    - Openings exist in current care coordination services because additional help is needed for outreach to families who need the services
- What is the accountability for a statewide behavioral health plan for all children? Where can families go to get help with this if the state doesn't comply?
- Focus on what's working here in CT and claim it—stop buying into evidence-based practices from other states.

Participant Comments on this Facilitated Discussion

- Appreciated opportunity to share personal perspectives
- Will have best feedback and rich diversity by going to existing groups in the state
- Appreciated style and format that led to thoughtful, open discussion, and positive tone