Children's Mental Health Advisory Committee
Committee Meeting Summary
September 8, 2014 (1:00 pm – 3:00 pm)
Value Options, Hartford Room

Advisory Committee Members Present: Abby Anderson, Ron Angoff, Patricia Baker, Tanya Barrett, Jen Bogin, Dan Connor, Anne Melissa Dowling, Pam Ferguson, Sarah Eagan, Hector Glynn, Bill Halsey, Allon Kalisher, Mark Keenan, Steven Korn, Andrew Lustbader, Melissa Mendez, Judith Meyers, Morna Murray, Bert Plant, Stephen Tracy, Doriana Vicedomini, Jesse White-Frese

Members Absent: Yoellie Iglesias, Winston Johnson, Myra Jones-Taylor, Peter Panzarella, Pat Rehmer, Charlene Russell-Tucker, Ann Smith, Vicki Veltri, Fred Volkmar, Celeste Warner, Mark White, Elaine Zimmerman

Others Present: Chris Bory, Sue Graham, Michael Hoge, Tim Marshall, Scott Newgass

Attachments

1. Agenda
2. Executive Summary

Proceedings

A. Welcome and Introductions: Judith Meyers called the meeting to order and welcomed members followed by a round of introductions. Meyers provided a summary of recent developments in preparation of the Children's Behavioral Health Plan:

- A draft was sent at the end of August to Committee members for review and comment;
- 19 of 35 members submitted feedback forms.
- The writing team, facilitated by the Child Health and Development Institute (CHDI), developed an integrated summary of the feedback forms categorized according to major themes.
- Commissioner Katz and other senior DCF staff reviewed the Draft Plan, the feedback forms and the integrated summary of feedback and made recommendations for revisions.
- The writing team made the suggested revisions and posted the revised draft to www.plan4children.org on Friday afternoon (9/5/14) for public comment.
- DCF hosted a media conference call on Friday afternoon (9/5) that was attended by major media outlets. Some details of the draft plan were discussed but the primary purpose for media coverage was to alert the general public about the opportunity to comment on the draft Plan.
- As of 9/10/14 (1:30 pm), 32 feedback forms have been submitted via the website (some from Committee members, most from the public). The deadline for submitting feedback is 9/12/14 - 5:00 pm.
- After reviewing all submitted comments, the writing team will revise the draft, which will then be forwarded to Commissioner Katz and DCF senior team members for final review.
- Commissioner Katz will submit the final plan to the legislature by October 1, 2014.

Other introductory comments:

- A Three-Branch executive meeting conflicted with this Committee meeting, resulting in some absences for this meeting.

- Dr. Meyers thanked the Committee for their commitment and hard work in reviewing the draft Plan and providing useful feedback.
- In order for the Plan to remain as concise as possible, not all feedback will be incorporated.
- The Advisory Committee should try to reach consensus on as many points as possible where there are differences of opinion.

B. Advisory Committee members had an opportunity to ask clarifying questions about the draft plan – which were fielded by Tim Marshall (DCF) and Judith Meyers (CHDI).

1) **Question: What are the major changes and revisions from the previous version?**
Response: In general, there were two levels of edits: (1) minor suggested edits and (2) major suggested edits. Nearly all of the minor suggested edits were useful and were incorporated into the draft. Major suggested edits focused on substantial content changes. Some, but not all of the major suggested edits were incorporated. Major changes included:
    a) Prioritizing goals and strategies emphasizing system integration (moving from last to first in the list of themes)
    b) Workforce Development was added as a major theme but specific strategies were integrated throughout the Plan.
    c) Recognition that screening and early identification occurs across all ages, not just in early childhood.
    d) Although changes were made to the section on commercial insurance, additional refinement is needed.
2) **Question: When is the deadline for the Plan?**
Response: PA 13-178 indicates a due date for submission of 10/1 and the Committee is still operating on that timeline.
3) **Question: What is the communication strategy for the Plan?**
Response: Communication strategy will be added to the agenda for the next Advisory Committee meeting. The Committee should plan to discuss the release of the final plan and the role that Committee members may play in that release.
4) **Question: Is New Jersey's Care Management Entity system the example for the Plan?**
Response: It is one example, but Tim Marshall indicated that DCF and others have looked at 15 to 20 states currently using a Care Management Entity (CME) system. The unique contribution of the New Jersey strategy is integration of public and private funds. The Plan aims to provide specific recommendations about the use of CMEs without being too prescriptive about the exact model.

C. A general discussion and suggested specific revisions followed.

<u>General</u>

1) There was strong recognition and acknowledgement of the dramatic improvement in this draft compared to the first draft delivered to the Advisory Committee Members in late August.
2) The Plan should highlight where more analysis is needed and acknowledge that it does not offer all of the answers. The Plan should clearly articulate the five-year process and resources needed to move ahead with implementation.
3) Members supported moving the "System Organization, Financing, and Accountability" to the first thematic area, which helps emphasize the primary focus of the Plan on addressing the fragmentation in the system.

4) Some Committee members indicated that the Plan is moving in the right direction but there needs to be a stronger call for immediate changes. We must supplement existing treatment services while making other system enhancements. One suggested recommendation was to call for an increase in the number of clinicians that are providing existing services.
5) Cost associated with Goals and Strategies was raised as a concern. Members were asked to review Appendix A, which pulls together all Goals and Strategies, with best estimates of associated costs; however, the committee will be asked for input on these estimates. The writing team found it difficult to ascertain the true costs of each Goal and Strategy. This refinement may be included in the next Plan iteration.
6) Emphasize that families face multiple issues beyond a child's mental health concerns including poverty, adequate food, transportation, employment, and housing. Acknowledge that family support should be holistic.
7) Members suggested avoiding strategies that involve more needs assessment. The concern is that needs assessments stall progress, avoid accountability, and may result in no action.
8) Acknowledge significant overlap of this Plan with other documents and task forces (e.g., Sandy Hook Advisory Commission, Taskforce on Adolescents and Young Adults). Align this Plan with those initiatives and reports.

Specific comments/recommendations by Theme

<u>Introduction</u>

1) Plan needs stronger expression of what children generally need to be healthy, e.g., the evidence-supported "pillars of well-being" (see a Robert Wood Johnson Foundation Child Trends report (July 2014 and work by Brian Samuels). Possible ideas include holistic services, evidence-based services, family driven system, lifelong learning, and sense of community. In making this point, however, ensure that the Plan is not intended to be a tome of the entire spectrum of all factors related to children's behavioral health.
2) Plan should emphasize use of research and science to inform policy and practice, as well as the use of data and quality improvement. Plan should highlight the need to direct resources to those programs that have proven to be effective.
3) Greater emphasis on the ecological framework of the child that encompasses mental health, physical health, and emotional health. Supportive context of overall well-being.

<u>System Organization, Financing, and Accountability</u>

1) There is a need to clearly justify spending money on infrastructure development (e.g., a Care Management Entity (CME) model) to avoid perception that this is a diversion of money from direct services.
2) Consider stronger narrative on a fully integrated behavioral health system, integrating voices from practitioners, families, and other stakeholders supporting this need. Will help make the case for investing in infrastructure development.
3) If a CME model were used, it would need to fit within CT's current fee-for-service model – CT being one of only a few states not using a managed care approach.
4) The Plan should strongly consider the appropriateness of a *regional* network of CMEs for CT. If regional CMEs were implemented, it could result in a parallel and duplicative network of care coordination services.

5) Consider including more about the potential role of value-based reimbursement. Define and operationalize what value-based purchasing is and how it is funded.
6) All funded programs should be held accountable for the money spent on the program. Implementing a Quality Assurance/Quality Improvement plan is recommended across programs and services.
7) Narrative under Goal A.3 (bullets) should be examined to address concerns about tone. The goal for this part of the Plan should be to "start a conversation" that involves commercial insurance.
8) Throughout Goal A.4 (Data Collection, Management, Analysis, Reporting), include the terminology of "meaningful use certified" electronic health records to align with the language in the Affordable Care Act (ACA).

Health Promotion, Prevention, Early Identification

1) Consider using the term "neurodevelopmental disorders" as a more appropriate term than "autism."
2) Include recommendations for capacity building/workforce development and increasing capacity of Birth to 3.
3) Continue to emphasize the stigma associated with receiving behavioral health services for the child and the parent. This was highlighted on page 29.

Access to a Comprehensive Continuum of Care

1) Too much focus on high emergency department utilization, which is a symptom of an underlying problem but not the underlying problem itself. The underlying problem is not clearly identified in the Plan.
2) The Plan does not adequately address the needs of children with co-occurring or neurodevelopmental disorders. The paucity of services for this population should be included under Strategy C.1.2 (Create and implement a service development and financing plan to guide the build out of the full continuum of services).
3) Include more on inpatient capacity
4) Include a recommendation on increasing school climate (possibly Positive Behavioral Intervention and Supports (PBIS).
5) Regarding the decrease in residential care – concern about the paragraph on occupancy data; suggestion is that unoccupied beds may be due to lack of authorization for this level of care not that these beds are not needed. The decrease in funding/authorization for residential treatment beds should be mentioned in this section.
6) There needs to be more on development of evidence-based practices across the continuum of care. A value-based reimbursement system would incentivize providers to implement evidence-based practices for the enhanced rates.
7) Emphasize use of research and science to inform policy and practice, as well as the use of data, quality improvement, and research. Highlight the need to direct resources to those programs that have proven to be effective.
8) Include following sentence from Executive Summary in the full report: "it was widely recognized by stakeholders that students are best prepared to learn when they are healthy and equipped with social, emotional, and behavioral regulation skills and competencies."
9) The recommended increase in school-based services was supported but continue to highlight school district's budget constraints.

10) Address the obligation of schools beyond simply identifying mental health needs. Can mention that schools can be expected to work with all children and the school system to address issues with: (1) discipline policy; (2) grading system; (3) literacy. Left unaddressed, these issues can lead to or exacerbate mental health problems.
11) Bullet on Autism under Strategy C.1.2 includes an incomplete sentence.
12) Consider including strategy for workforce development for EMPS clinicians to increase capacity for working with specialized population, specifically autism/neurodevelopmental disorders.

Pediatric Primary Care and Mental Health Care Integration

1) Recommend using the term "pediatricians" instead of "physicians" and focus on capacity building required for pediatricians in the workforce development and integrated care sections.

Disparities in Access to Culturally Appropriate Care

1) If standardized assessment measures are recommended, ensure that the measures are evaluated to ensure the absence of any implicit racial bias.
2) Make clear how data would be disaggregated by race/ethnicity to examine cultural and linguistic competence. Clearly indicate that disaggregated should be used to examine issues of access, quality, and outcomes.

Workforce

1) Training for officers in behavioral health. Consider CT Alliance to Benefit Law Enforcement's (CABLE) Crisis Intervention Team (CIT) trainings and other related programs and initiatives.

Implementation

1) Clearly identify priorities and a timeline, even if full details are not provided.
2) Given projected budget deficit, Committee can help to identify priorities and ensure accountability for dollars spent.
3) Include a visual representation of the Plan with priorities, process, and timeline. Consider the public health framework in developing this visual.

D. Next Steps

1) **Next meeting:** Monday, September 22 (1:00 pm–3:00 pm). ValueOptions, 3rd Floor Hartford Rm.