**Department of Mental Health and Addiction Services (DMHAS)**

**Information Requested for Agency Work Session w/Appropriations Health Subcommittee**

**Substance Use Disorder (SUD) Waiver**

1. Detail on funding changes (ex. General Assistance Managed Care (GA) to Medicaid, Grants for non-Medicaid eligible).
2. Will clients receive the same services?
3. How will the waiver impact providers?

**American Rescue Plan Act (ARPA) Funding**

4. Which ARPA initiatives have ongoing costs? What is the impact of one-time funding? Can we help providers plan for the cliff?
5. Please share the Request Fro Proposal (RFP) for Electronic Health Records (EHR)- can you breakdown anticipated costs?
6. Detail funding related to forensic beds- how many beds and where will they be? Who will provide services?
7. Mobile Crisis services- current program stats/utilization, list of providers, description of both allocations (24/7 and post crisis case management).
8. Peer Supports- How many peers will this place? Which emergency departments?
9. Housing vouchers- what services does this funding support and where are the units located?
10. How many clients are in need of telehealth equipment?

**Diversity Focus**

11. How does DMHAS currently address training, service selection, provider contracts and service delivery through a diversity, equity and inclusion lens?
12. Can you identify prevention and treatment funding that is specifically geared towards the Hispanic community?
13. Can you identify non-profit organizations operated by the Black, Indigenous and People of Color (BIPOC) community (and what services do they provide)?

**Staffing Update**

14. How many vacancies? active recruitments? anticipated hires?
15. How many retirements do you anticipate over the next several months and does DMHAS have a plan to address those losses?

**Problem Gambling Services**

16. Please provide the number of people historically using these services compared to current data.

**Prevention**

17. Detail funding and associated programs focused on substance use prevention, particularly cannabis and vaping.

**Military Support Program**

18. Update on the military support program- how much funding and what does it support? How many people are we serving?

**Tobacco Funds**

19. Historical use/involvement with Tobacco settlement funds.

Department of Mental Health and Addiction Services

## SUD Waiver

## 1. Detail on funding changes (ex. GA to Medicaid, Grants for non-Medicaid eligible)

| | | |
|---|---|---|
| Personal Services - Staff | $2,006,742 | Funds 25 new positons to support clinical improvements (meet ASAM level of Care requirements) for the substance use services at CVH : 5 Utilization Review Nurses, 11 Licensed Clinical Social Workers, 6 Recovery Support Specialists, 1 Eligibly Services Worker, 2 Behavioral Health Program Managers. |
| Other Expenses - Administrative Services | $5,185,020 | Fund contracts with Administrative Services Organizations to support provider training, certification, monitoring, and utilization management. |
| GA Managed Care - Medicaid Individuals | ($24,630,463) | Shifts funding to DSS (under Medicaid) for SUD residential services that become Medicaid reimbursable services under the new waiver. |
| Grants for Substance Abuse Services -- Contracts for Non-Medicald Individuals | $11,698,978 | Fund SUD residential services for non-Medicaid eligible individuals in private provider contracts at rates consistent with Medicaid rates. |
| **Total** | **($5,739,723)** | |

## 2. Will clients receive the same services?

A. It is anticipated individuals seeking treatment at Connecticut's Substance Use Disorder Residential Services (Intensive Residential, Intermediate Residential, Intermediate Residential for Pregnant and Parenting Women, Long Term Residential and Transitional/Halfway House) will receive improved services as the SUD waiver will allow Connecticut (CT) to be eligible for Medicaid Federal match for all of these levels of care (about 900 beds) and those additional federal funds will be reinvested back into services allowing CT to financially support providers to add multidisciplinary staff, and standardize care across each level of care.

B. Providers will evaluate each resident according to the 6 dimensions of American Society of Addiction Medicine.

DIMENSION 1: Acute Intoxication and/or Withdrawal Potential
DIMENSION 2: Biomedical Conditions and Complications
DIMENSION 3: Emotional, Behavioral or Cognitive Conditions and Complications
DIMENSION 4: Readiness to change
DIMENSION 5: Relapse, Continued Use or Continued Problem Potential
DIMENSION 6: Recovery/Living Environment

This standard multi-dimensional evaluation will assist in matching each individual with the most appropriate level of care to meet their needs upon entry into treatment and across all inpatient and outpatient levels of care, helping to create seamless transition between levels of care.

## SUD Waiver

## 3. How will the waiver impact providers?

The SUD waiver will allow CT to be eligible for Medicaid Federal match for all of these levels of care (about 900 beds). Those additional funds will be reinvested back into services allowing CT to financially support providers with increased rates to add multidisciplinary staff and standardize care across each level of care.

DMHAS, sister state Departments and the Administrative Services Organizations will work closely with existing SUD residential providers over a 24-month period to assist them to meet the new CT standards of care which are based on standards set out by the American Society of Addiction Medicine.

Department of Mental Health and Addiction Services

**ARPA Funding**

**4. Which ARPA initiatives have ongoing costs? What is the impact of one-time funding? Can we help providers plan for the cliff?**

| DMHAS SFY 23 Governor's Budget - Federal Coronavirus State Fiscal Recovery Funds (CSFRF) | | | |
|---|---|---|---|
| | | | |
| **Initiative** | **State Fiscal Year (SFY) 23** | **SFY 24** | **Estimated Future Annualized Costs** |
| Provide Mental Health Peer Supports in Hospital Emergency Departments | $1,200,000 | $1,200,000 | $1,200,000 |
| Fund Diversity Training (1) | $139,000 | $155,000 | $0 |
| Implement Electronic Health Records (2) | $10,000,000 | $6,000,000 | $4,000,000 |
| Enhance Mobile Crisis Services | $3,000,000 | $3,000,000 | $3,000,000 |
| Enhance Respite Bed Services for Forensic Population | $1,429,133 | $1,909,134 | $1,909,134 |
| Expand Availability of Mobile Crisis Services | $1,600,000 | $1,600,000 | $1,600,000 |
| Support Client Telehealth Equipment | $1,000,000 | $200,000 | $0 |
| Fund Supportive Services to Accompany New Housing Vouchers | $1,125,000 | $1,125,000 | $1,125,000 |
| **Total** | **$19,493,133** | **$15,189,134** | **$12,834,134** |
| * Braid with $19M from bond funds | | | |

(1) Future training services will be conducted through train the trainer programs. Additional programs will be sustained with money such as General Fund, Opioid Settlement Funds, Medicaid or Federal Grant Funds.

(2) DMHAS anticipates the services we would stand up using ARPA funding in the Governor's Budget would be sustained in the out years with a two-fold approach: (1) some services will be picked up under Medicaid and (2) to state funding where it would be needed. An example of this would be the mobile crisis services and the commitment from the Governor. "The Governor is also mindful of the need to create sustainable programming when the CSFRF funding expires. Department of Children and Families and DMHAS, along with the Department of Social Services (DSS), will be pursuing a provision in federal law that allows for an 85% Medicaid match on mobile crisis services over a 36-month period for eligible services provided by mobile crisis teams".

## 5. Please share the RFP for electronic health records- can you breakdown anticipated costs?

This is currently an active RFP and contract negotiations are in progress, therefore anticipated costs cannot be shared at this time.

Please see the RFP attached document

Department of Mental Health and Addiction Services

## ARPA Funding

## 6. Detail funding related to forensic beds- how many beds and where will they be? Who will provide services?

Additional funding of $1,429,133 for SFY 23 will be added to build additional capacity for community competency evaluations and restoration to competency activities for repeat offenders of misdemeanors from 3 to 15 beds expanding capacity from Bridgeport to New Britain and New Haven Courthouses. In SFY 24, $1,909,134 will be added for a total cost of $127,275/bed.

In October 2021, DMHAS inaugurated a pilot Enhanced Forensic Respite Bed program in Bridgeport, in affiliation with the Recovery Network of Programs (RNP), the private non-profit agency that operates the program. This program provides three respite beds for diversion of defendants charged with misdemeanor-only crimes in the Bridgeport court, who might otherwise be referred for evaluation of competence to stand trial and restoration if found not competent because of mental illness. The anticipated length of stay is 30 days in a 24/7 staffed, intensive residential program in the community. The pilot targets defendants with repeated arrests, housing instability, nonadherence to mental health treatment, and substance use who might otherwise be sent to Whiting Forensic Hospital for restoration and aims to maintain them in the community, in treatment, rather than in the criminal justice system. The program provides appropriate clinical stabilization, peer supports, case management, restoration or initiation of entitlements, and referrals to longer-term housing and ultimately permanent housing, and employment supports when possible. The model has the potential for expansion to include increased court referrals to outpatient restoration, and capacity for transfer of restoration efforts from inpatient to outpatient (CGA 54-56d(j)(5)). The current proposal would expand this pilot program to five beds and inaugurate similar pilots in other courts/cities in programs managed by other private community agencies experienced with operating mental health and substance use respite beds for stabilization. We would expand from one court served to three courts served, each with five beds.

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## ARPA Funding

## 7. Mobile Crisis services- current program stats/utilization, list of providers, description of both allocations (24/7 and post crisis case management).

SFY 21 utilization of mobile crisis is 13,332 contacts. Please see attached mobile crisis report for additional information.

Mobile Crisis Report

## ARPA Funding

## 8. Peer Supports- How many peers will this place? Which emergency departments?

DMHAS will utilize twelve of the State's busiest emergency departments to replicate a peer support model that has been proven successful in substance use treatment and is in the process of reviewing the data and operationalizing a plan for the busiest emergency departments.

## 9. Housing vouchers- what services does this funding support and where are the units located?

The funding is to support existing vouchers where the individuals cannot be placed without wrap around supports. DMAHS supports wrap around services for clients throughout the State.

Individualized Supports include in home case management, budget management, care coordination, landlord negotiation and mediation, peer support, daily living skills, referral to employment, education, assisting with social and family connections, access and referral to medical, mental health, substance use care, transportation, and integration into the community.

In Connecticut, Supportive Housing has proven to be a cost effective model to reducing homelessness among those individuals that are living with a mental illness or substance use disorder. Supportive Housing combines affordable housing, most often through a rental subsidy, with intensive yet flexible support services. These Statewide services focus on housing based case management, or assisting the tenant reintegrate into the community by teaching him/her the basic skills of tenancy. Supportive Housing has proven to reduce higher cost institutional services, such as homeless shelters, inpatient psychiatric and physical hospitalizations, as well as readmission into the criminal justice system.

Department of Mental Health and Addiction Services

## ARPA Funding

## 10. How many clients are in need of telehealth equipment?

Distribution will be based on client need through an application process with State operated and private behavioral health providers.

## Diversity Focus

## 11. How does DMHAS currently address training, service selection, provider contracts and service delivery through a diversity, equity and inclusion lens?

DMHAS partners with a full service diversity and inclusion consulting firm to assist with building internal capacity with the formation of a mandatory 7-hour Diversity, Equity and Inclusion Training program. Additional ongoing training topics include but are not limited to: leadership, mediation, supervision, relationship building, and courageous conversations. DMHAS collaborated with the Governor's Office and the Department of Children and Families along with academic institutions, faith-based organizations and community organizations to host a series of community conversations during the pandemic. The goal of these conversations is to disseminate recommendations regarding strategies for addressing racism and bias for local and larger systems improvements and to build and bridge community alliances.

DMHAS will continue to address diversity, equity and inclusion in the following ways: (a) Social Justice Committee will collaborate with Union Leadership quarterly to discuss social justice, diversity, equity, and inclusion concerns with staff; (b) DMHAS provider contracts address language to access and ensure that the mandatory 3-hour diversity training is provided for all new employees; (c) The IMANI Breakthrough program and Mobile Medication Assisted Treatment program are some examples of programs and services that address needs of racial, ethnic and cultural groups. DMHAS continues to evaluate the needs of staff and clients to ensure there is an equitable and inclusive environment for all. With additional funding, DMHAS will continue to amplify these efforts.

Department of Mental Health and Addiction Services

## Diversity Focus

## 12. Can you identify prevention and treatment funding that is specifically geared towards the Hispanic community?

| Provider | Program Name | Contract Scope | SFY 21 |
|---|---|---|---|
| Catholic Charities | Case Management Hispanic Family | Mental Health (MH) Case Management | $205,815 |
| Catholic Charities | Multiple | Substance Abuse (SA) Outpatient | $203,450 |
| Catholic Charities | Latino Outreach Program | SA Outreach | $47,866 |
| Chemical Abuse Services Agency, Inc. | Multiple | SA Outreach | $95,810 |
| Chemical Abuse Services Agency, Inc. | Project Nueva Vida | SA Outpatient | $76,913 |
| Communicare, Inc. | Multiple | MH Outpatient | $586,064 |
| Community Mental Health Affiliates | Latino SA Outpatient | SA Outpatient | $127,783 |
| Hartford Behavioral Health | Multiple | MH Outpatient | $886,834 |
| Hispanic Health Council, Inc. | Hispanic Health Council | Vocational Rehabilitation / Employee Opportunities | $145,000 |
| Midwestern Connecticut Council On Alcoholism, Inc. | Latino Outreach | SA Outreach | $43,550 |
| Optimus Health Center Inc. | Latino Outreach | Community Support Program | $131,021 |
| Optimus Health Center Inc. | Project Nueva Vida | SA Case Management | $33,188 |
| Perception Programs, Inc. | Case Management Latino Outreach Initiative SA | SA Outreach | $38,869 |
| Perception Programs, Inc. | Case Management Latino Outreach Initiative MH | MH Outreach - Homeless | $45,912 |
| Rushford Center, Inc. | Latino Clinical Program | MH Outpatient | $865,050 |
| Wheeler Clinic, Inc. | Latino Outreach | SA Outreach | $50,128 |
| Yale University | Connecticut Mental Health Center (CMHC) Hispanic Clinic | SA Outpatient | $155,962 |
| Yale University | CMHC Hispanic Clinic | MH Outpatient | $1,184,647 |
| **Total** | | | **$4,923,862** |

Department of Mental Health and Addiction Services

**Diversity Focus**

**13. Can you identify nonprofit organizations operated by the BIPOC community (and what services do they provide)?**

As part of our communications strategy, we ensure that our campaigns are reaching historically underserved communities, in particular, multicultural and diverse audiences with in-language and in-culture messaging that resonates within the communities.

**DMHAS Campaign: SMI (Serious Mental Illness)**

As part of the media mix to effectively reach Black, Indigenous, Latino, and people of color (BIPOC), the SMI campaign contains the following elements:

**Social Media**

Each Social Media post has an English and Spanish counterpart, extending the reach beyond the general population to Spanish dominant and Spanish preferred communities

- Placement: Facebook & Instagram
- Targeted locations for social media include urban areas with highest diversity populations*, such as: New Haven, Waterbury, Danbury, and Bridgeport.

Please note: As of January 19, 2022, Facebook & Instagram have removed detailed targeting options that relate to topics people may perceive as sensitive, such as options referencing causes, organizations, or public figures; or that relate to race or ethnicity, political affiliation, religion, or sexual orientation.

**Out-of-Home (OOH) Media**

**Includes a mix of the following:**

- Digital Billboards
    - Throughout urban areas with highest diversity populations*:
        - Locations: Hartford, New Haven, Waterbury, and Bridgeport
- Newspaper Ads
    - Placements within African American & Latino newspapers popular within the respective communities:
        - Inner City News – estimated reach: 25K per insertion, 2x insertion
        - Inquiring News – estimated reach, 45K per insertion, 2x insertion
        - La Voz Hispana – estimated reach: 135K per insertion, 4x insertion
- Traditional Radio
    - Urban stations:
        - WYBC Urban Adult Contemporary
        - BKCI-FM HD The Beat - Hip Hop, R&B
    - Spanish language stations: Spanish language creatives on traditional radio reaching diverse audiences
        - WMRQ-F2 (Bomba): New Haven, New London, Bridgeport.
        - WRYM (Viva) 107.3 FM/840AM: Hartford/Springfield Spanish
        - WWCO (Viva) 106.3 FM/1240 AM: Waterbury/New Haven Spanish
- Indoor Screens in Latino supermarkets - Spanish language
- Indoor Spanish Language Posters – throughout key Latino demographic locations: Hartford, New Haven, and Waterbury

Please note: Reach is estimated, final impressions and engagement to be delivered at close of campaign.

**CTStronger.org Website (COVID 19 and Mental Health Information)**

- There is a google translate drop down menu integrated into the site for the ability to change the content on the site to any language
- In addition, there is an accessibility area which assists with vision impaired, etc.

*Based on the 2020 Census data, Connecticut towns with the highest Diversity Index include: New Haven, (73%), Waterbury (69%), Bridgeport (68%), Hartford (66%), and Danbury (60%).

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## Staffing Update

## 14. How many vacancies? Active recruitments? Anticipated hires?

At present CORE/CT (Core-CT is the name given to Connecticut's HRMS (Human Resource Management System) / Financials system) has 810 vacancies (Full time, Temporary Worker Retiree, Part time, Emergency Worker and Temporaries). There is some overlap and duplication as some vacancies have/will be filled by temporary or emergency employees who will moving into permanent positions. To date, 65 commitments to employment have been made.

Positions in active recruitment are positions that have received approval through OPM and have been entered into CORE and/or have been posted or placed on the transfer list. DMHAS is actively recruiting for 390 staff.

| Facility | Number of Vacancies by Facility | Positions Committed by Facility | Number of Positions in Recruitment | Positions Pending Further Review |
|---|---|---|---|---|
| Connecticut Valley Hospital | 389 | 5 | 121 | 263 |
| Capital Region Mental Health Center | 32 | 1 | 31 | 0 |
| Connecticut Mental Health Center | 43 | 6 | 37 | 0 |
| Office of the Commissioner | 68 | 14 | 40 | 14 |
| River Valley Services | 18 | 8 | 10 | 0 |
| Southeast Mental Health Authority | 33 | 2 | 28 | 3 |
| Southwest Connecticut Mental Health System | 97 | 13 | 51 | 33 |
| Western Mental Health Network | 47 | 5 | 42 | 0 |
| Whiting Forensic Hospital | 83 | 11 | 30 | 42 |
| **Total** | **810** | **65** | **390** | **355** |

Currently, retirement and vacancies caused by attrition are higher than employees onboarding.

DMHAS is actively working with DAS to approve hiring rates for hard to fill positions.

Department of Mental Health and Addiction Services

**Staffing Update**

**15. How many retirements do you anticipate over the next several months and does DMHAS have a plan to address those losses?**

DMHAS has been notified of 136 retirements occurring over the next few months.

Recruitment Plans:

A. In the process of creating a staffing unit which will focus solely on DMHAS staffing/filling of positions.

B. Candidate pools have been created for positions such as Licensed Practical Nurse's and Mental Health Assistant's to increase the speed/quantities of hires.

C. DMHAS is advertising for psychiatrist positions in the American Journal of Psychiatry/American Psychiatric Association and nursing positions in the Connecticut Nurse Update.

D. Outreach Conducted by Talent Solutions for all job postings include:
- Minority based organizations
- Social media
- Community based organizations
- Professional organizations
- Colleges and Universities
- Career Fairs/Virtual & in-person
- Agency communication upward mobility

Below are the job fairs DAS currently has scheduled for this year:

| Fair Details | Date and Time | Location |
|---|---|---|
| CT SHRM (Partnered with HYPE and Urban League of Greater Hartford) | 1/26/2022 10am-2pm | Virtual (WHOVA) |
| Uconn Internship/Co-op | 2/1/2022 11am-2pm | Virtual (Handshake) |
| CCSU All Major Career & Internship Fair | 2/8/2022 1pm-4pm | Virtual (Handshake) |
| CCSE Engineering, Manufacturing & Construction Management Fair | 2/24/2022 4pm - 7pm | Virtual (Handshake) |
| Uconn Careers for the Common Good (Nonprofit organizations, government agencies) | 3/1/2022 11am-3pm | Virtual (Handshake) |
| Quinnipiac School of Business and Engineering Spring Career Fair | 3/3/2022 3pm - 5pm | In Person (Athletic Center AC 120 Burt Kahn Court 275 Mt Carmel Ave, Hamden, CT 06518 |
| Uconn Career Fair | 3/29/2022 11am - 3pm | In Person ( Gampel Pavilion 2098 Hillside Road, Storrs, Connecticut 06269 |
| Uconn Career Fair Virtual | 3/30/2022 11am - 3pm | Virtual (Handshake) |
| CCSU Education Career Fair | 4/5/2022 2pm - 5pm | Virtual (Handshake) |

Department of Mental Health and Addiction Services

**Problem Gambling Services**

**16. Please provide the number of people historically using these services compared to current data.**

| Month | FY 17 | FY 18 | FY 19 | FY 20 | FY 21 | |
|---|---|---|---|---|---|---|
| July | 254 | 210 | 178 | 209 | 156 | |
| August | 250 | 213 | 182 | 207 | 152 | |
| September | 246 | 205 | 183 | 203 | 152 | |
| October | 248 | 197 | 192 | 198 | 157 | |
| November | 244 | 186 | 197 | 196 | 159 | |
| December | 234 | 190 | 196 | 191 | 158 | |
| January | 235 | 190 | 206 | 188 | 158 | |
| February | 232 | 188 | 199 | 196 | 168 | |
| March | 234 | 184 | 211 | 197 | 169 | |
| April | 231 | 188 | 217 | 192 | 180 | |
| May | 215 | 193 | 216 | 187 | 177 | |
| June | 214 | 193 | 213 | 182 | 178 | |
| **Total** | **2,837** | **2,337** | **2,390** | **2,346** | **1,964** | **11,874** |

Since 1982, Problem Gambling Services in the Connecticut Department of Mental Health and Addiction Services has funded prevention, intervention, treatment and recovery support services guided by a public health approach that considers the biological, behavioral, economic and cultural determinants that influence gambling and health. This approach incorporates a balance of outreach, education, prevention, treatment and recovery support efforts that work together to minimize the potential negative impacts of gambling on individuals, families and communities, and recognizes gambling's availability, cultural and social acceptance, as well as monetary appeal. Bettor Choice Treatment provides counseling for problem gamblers and those affected by the gambling of a family member. This includes telehealth options for eligible persons with barriers to accessing certain face-to-face treatment services. Types of treatment available include individual, couples, family, and group therapy in addition to medication management. All clinicians providing services are master's level and licensed or licensed eligible. Clinicians are also required to obtain the International Certified Gambling Counselor (ICGC) certification or are working towards obtaining this certification. Peer Recovery Supports are on staff and provide case management, financial counseling, and other support services. Bettor Choice programs accept insurance when possible and have DMHAS grant funding to significantly decrease or eliminate financial costs, since financial issues are a known barrier for accessing services. Bettor Choice programs were re-procured in the Fall of 2019 and new contracts were executed January 1st 2020. Part of the procurement process was an alignment of service requirements/expectations, as well as a standardization of funding throughout the five DMHAS regions. Between State Fiscal Year (SFY) 17 through SFY 21 approximately 12,000 citizens statewide have received counseling services (see attached Excel spreadsheet). PGS contracts with local agencies to provide problem gambling prevention, treatment and recovery support services statewide. Problem gambling treatment programs are licensed by DPH and are selected for contracting through a competitive request for proposals process. Helpline referral and education: PGS is legislated to provide funding (CGA 17a-713) to the CT Council on Problem Gambling (CCPG), of which a portion goes toward funding the Problem Gambling Helpline. Individuals have access to resources and education through the CT problem gambling Helpline, telephone (888) 789-7777 or Text "CTGAMB" to 53342 options, and the CT Council on Problem Gambling website (https://ccpg.org).

Prevention Services:

Problem gambling education and prevention services inform participants about the risks and responsibilities of gambling. This work encompasses the six prevention strategies identified by the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention: community-based process, environmental, information dissemination, education, alternatives, and problem identification and referral. Initiatives include: health promotion campaigns to encourage CT residents to evaluate their gambling behavior and seek help if they have a problem (Includes collaborative health promotion activities with the CT Lottery and the two tribal casinos); partnering with the CT Lottery to inform players that help is available for problem gambling; school-based prevention efforts for youth and educating the problem gambling treatment and prevention workforce on regional, statewide, and national trends and best practices aimed at continuous quality improvement in service delivery and outcomes.

Regional Gambling Awareness Teams provide a framework for CT's statewide gambling awareness prevention initiative. There are Regional Gambling Awareness Teams in each of the five DMHAS regions that focus on gambling informed prevention, intervention and treatment across the continuum of care and across the lifespan. The teams meet on a quarterly basis and each convening can range from 90 minutes to several hours in duration. Select meetings are identified as topic-specific and offer Continuing Education hours to participants. Members represent prevention, treatment, recovery and local community stakeholders. The focus of the teams is to increase the capacity of local communities to be "gambling informed"; strategically gather and assess community readiness data, and review and assess select programs for gambling awareness infusion; and strengthen, support and inform statewide gambling awareness infrastructure. Team members work to achieve the Gambling Awareness Certificate of Competency.

Congregation/Community Assistance Program (CAP): Provides trainings to faith based and local businesses/organizations throughout the state on topics such as raising awareness of the impacts of behavioral health concerns, including addiction, mental health, gambling and suicide; and mechanisms on how to identify and refer associate members for local assistance and support.

The Youth Peer Leadership and Media Development is currently organized through three important partnerships. Capitol Region Education Council (CREC) oversees statewide initiative working with one identified youth group in each of the five Regions on youth-led development and creation of a gambling awareness Public Service Announcement (PSA). The PSA's are released during Problem Gambling Awareness Month (PGAM) in March and featured at statewide youth-led peer leadership conference (each select group consists of five-ten youth with one-two adults); Regional Behavioral Health Action Organizations (RBHAO) identify a youth group from the region they represent, then are tasked with coordinating the youth media project in conjunction with CREC; and Bridgeport Caribe Youth Leaders (BCYL) conduct community-based education and skill building with identified groups of eight-ten middle and high school Latino youth, and provide ongoing training in gambling awareness, public speaking, and leadership skills. Trainings take place twice a month. Youth leaders partner with parents, schools and community organizations to deliver a minimum of three presentations on gambling awareness messages, including how to identify and refer those in need of assistance with problem gambling.

Asian American Pacific Islander (AAPI) program reflects a collaboration between PGS and Amplify (the region 4 RBHAO) to raise awareness about gambling in AAPI Communities. Six members of AAPI communities are identified and trained in gambling awareness and the evidence-based Community Conversation Model to outreach into their own communities for conversations on gambling, problem gambling, and how to access help for those in need of assistance with gambling concerns. Initiative currently being evaluated and will serve as a model for future collaborations with other identified populations and communities perceived as "at-risk" for developing gambling problems.

Department of Mental Health and Addiction Services

**Prevention**

**17. Detail funding and associated programs focused on substance use prevention, particularly cannabis and vaping.**

**Estimated FFY 2021 Prevention Budget**

| Connecticut Prevention Budget | | | | |
|---|---|---|---|---|
| **Program Area** | | **Revenue Source and Amount** | | |
| **(e.g., statewide prevention contractors, grants, and program areas** | **Purpose/Uses** | **SABG/Federal** | **State Funds** | **Total** |
| Prevention in CT Communities | Develop and implement a strategic plan to reduce ATOD among 12-20 year-olds in 8 communities across the state. | $1,250,000 | $0 | $1,250,000 |
| Local Prevention Councils (LPC) Program | Funds municipal based prevention councils representing 169 towns to reduce vaping use rates by 5% by 2025 among 12-18 year-olds. | $702,010 | $0 | $702,010 |
| Courage to Speak Foundation | Provide substance abuse prevention education for parents and youth in school and community settings across the state. | $20,000 | $0 | $20,000 |
| CT Clearinghouse | Maintain a clearinghouse for the collection, dissemination and training on behavioral health and related information and materials. | $1,352,264 | $72,147 | $1,424,411 |
| Governor's Prevention Partnership (GPP) | Promote youth development and mentoring statewide through partnerships with schools, campuses, workplaces and the media. | $296,352 | $396,816 | $693,168 |
| Training and Technical Assistance Services Center (TTASC) | Assess the prevention workforce training needs and maintain a statewide workforce development training program that promotes Prevention Certification. | $350,000 | $0 | $350,000 |
| Regional Behavioral Health Action Organizations | Assess, plan and provide for the behavioral health needs of children, adolescents and adults across the five regions. | $1,711,070 | $308,024 | $2,019,094 |
| MOSAIX IMPACT Data Collection System | Provide a cloud-based service to meet the state and federal data collection, management, and reporting requirements. | $92,016 | $0 | $92,016 |
| Center for Prevention Evaluation & Statistics (CPES) | Track, collect, analyze and disseminate behavioral health data to inform prevention services and programs. | $350,000 | $0 | $350,000 |
| Synar Merchant Education | Produce and distribute educational and awareness materials to approx. 5,000 retailers to promote compliance with CT tobacco/ENDS laws. | $97,330 | $0 | $97,330 |
| | | **Revenue Source and Amount** | | |
| **Program Area** | | **SABG/Federal** | **State Funds** | |
| **(e.g., statewide prevention contractors, grants, and program areas supported by the SABG prevention set aside and other prevention funds)** | | **Funds Allocated** | **Allocated** | **Total** |
| FDA Tobacco Retailer Inspections Program | Conduct inspections of CT tobacco and ENDS merchants for compliance with provisions of the FDA 2010 Tobacco Control Act. | $1,361,738 | $0 | $1,361,738 |
| Strategic Prevention Framework for Prescription Drugs (SPF Rx) | Bring prescription drug abuse prevention awareness, activities and education to schools, communities, parents, prescribers, and their patients. | $371,615 | $0 | $371,615 |
| State Opioid Response (SOR) Grant | Fund a network of providers to use multi-faceted prevention strategies to prevent non-prescription opioid use and the progression from use of prescription opioids to heroin, fentanyl and other illegal opioids. | $2,841,838 | $0 | $2,841,838 |
| Prevention Unit Staff – Salaries & Fringes (7 FTE includes vacancy) | | $0 | $1,072,842 | $1,072,842 |
| | **Total** | $10,798,233 | $1,849,829 | $12,648,062 |

**Prevention Staff & Funds Assigned to Youth Vaping/Tobacco**
**Estimated FFY 2021 Budget**

| Initiative | Budget* | Staff Assigned | FTE |
|---|---|---|---|
| SYNAR: Enforcing State tobacco/ENDS Laws | $622,324 | Supervising Special Investigator | 1FTE |
| | | Special Investigator | 3FTE |
| FDA Contract to Conduct State Tobacco Retail Inspection | $1,361,738 | Supervising Special Investigator | 1FTE |
| | | Lead Special Investigator | 1FTE |
| | | Special Investigator | 3FTE |
| **Total** | $1,984,062 | | |

***Includes salaries, vehicle leases, fuel, purchase funds, materials and supplies***

2.5 million for cannabis for staff, media campaign, a consultant. We will get 25% of cannabis tax revenue for prevention and treatment once it starts coming in.

Department of Mental Health and Addiction Services

## Military Support Program (MSP)

### 18. Update on the military support program- how much funding and what does it support? How many people are we serving?

**MSP Funding**

- Currently the annual budget for the Military Support Program is $326,329.00
  - The program supports two (2) Community Clinicians that respond to all inquiries from the Telephone Call Center. These clinicians case manage the callers seeking services until they have successfully been linked and established to the appropriate resources in the community. They also support and assist the embedded clinicians with connecting service members to various clinical and case management services in the member's own community.
  - The program also covers 20 embedded clinicians cover 30 National Guard Units and are a resource and support to approximately 5,000 members.

**MSP Supports**

- Embedded clinicians at each unit provide support and referral for a broad range of behavioral health issues such as PTSD, depression, anxiety, and substance abuse disorders.
- MSP offers guard members a confidential alternative and option for support with clinical and case management issues. Many soldiers were reluctant to access behavioral health services prior to the implementation of MSP due to confidentiality concerns. The embedded clinicians work collaboratively with CTARNG leadership and the CTARNG behavioral Health Team to provide resources and assistance during critical incidents or other high risk events.
- MSP Clinicians participate in a variety of outreach and training activities ant the guard units and in various community settings such as educating service members on topics of suicidality, PTSD, depression, COVID-19, participating in Yellow Ribbon Events and multiple contacts with various staff and service members regarding staff and service member deaths.

**MSP SFY 23 Q1 and Q2 statistics**

- MSP program responded to 51 calls to the Call Center that resulted in 30 outpatient referrals to behavioral health services.
  - Five (5) claims were approved and paid for by MSP due to lack of insurance or concerns regarding confidentiality.
  - Seventeen calls resulted in referrals to various case management services
  - 4 call issues were resolve in a single session.
- Embedded Clinicians provided 108 supportive sessions to service members during drill.
  - This resulted in 47 referrals to behavioral health and case management resources in the service member's community for continued services.
  - Embedded clinicians also made 14 contacts to service members outside of drill weekends including to support service members who were actively deployed.
  - Embedded clinicians responded to four (4) critical events including a service member suicide.

Department of Mental Health and Addiction Services

## Tobacco Funds

## 19. Historical use/involvement with Tobacco settlement funds.

The last time DMHAS received funding for this was in 2015 for $287,000. Those funds were used for compliance inspections with the city Police Departments. Unfortunately, due to the number of staff retirements additional this historical information is not available at this time.

**Department of Mental Health and Addiction Services**
**Status Report on DMHAS Services that Provide 24/7 Options for Crisis Response**

## I. Introduction/Background Information

The Department of Mental Health and Addiction Services (DMHAS) provides mobile emergency crisis services to individuals ages eighteen (18) or older. Mobile emergency crisis services are mobile, readily accessible, rapid response, short-term services for individuals and families experiencing episodes of behavioral health (mental health and/or substance use) crises.

There are 18 adult Mobile Crisis Teams (MCTs) in Connecticut; 8 are DMHAS-operated and 10 are DMHAS-funded. The DMHAS-operated programs include Connecticut Mental Health Center (CMHC) in New Haven, Capitol Region Mental Health Center (CRMHC) in Hartford, River Valley Services (RVS) in Middletown, Southeastern Mental Health Authority (SMHA) in Norwich, Southwest Community Mental Health Center (SWCMHS) in Bridgeport and Stamford, and Western Connecticut Mental Health Network (WCMHN) in Waterbury and Torrington. The DMHAS-funded providers include BHCare in Ansonia and Branford, Bridges in West haven, Community Health Resources (CHR) in Manchester and Enfield, Community Mental Health Affiliates (CMHA) in New Britain, Danbury Hospital in Danbury, InterCommunity in East Hartford, Rushford in Meriden, and United Services in Dayville and Willimantic. All MCTs offer persons in distress (crisis) immediate access to a continuum of crisis response services of their choice including, mobile clinical services; family, peer and community supports; and/or mental health and addiction treatment. MCTs promote the prevention of crises among persons and families and provide postvention activities that support persons in developing a meaningful sense of belonging in their communities. MCT services are mobile and available wherever or however a person presents physically and emotionally (person-centered). Which MCT responds to an individual is defined by the DMHAS catchment area where the call came in. Crisis services and resources can be found on the DMHAS website using this link: https://portal.ct.gov/DMHAS/Programs-and-Services/Finding-Services/Crisis-Services.MCT staff provide immediate assistance to people in distress by identifying options and resources that meet the unique needs expressed by the individual. The MCT services are provided by the DMHAS Local Mental Health Authority (LMHA) Network, with one exception (Danbury Hospital). MCTs are comprised of a multidisciplinary team, which may include licensed master's level social workers, licensed clinical social workers, licensed professional counselors, other licensed clinicians, peer support specialists, nurses, and mental health workers.

### ***DMHAS Mobile Crisis Mission Statement***

To provide persons in distress (crisis) immediate access to a continuum of crisis response services and/or supports of their choice including, mobile clinical services and community supports; to promote the prevention of crises among persons and families; and to provide postvention activities that support persons in developing a meaningful sense of belonging in their communities.

### ***DMHAS Mobile Crisis Program Services***

All DMHAS MCTs provide the following services and supports:

- Outreach and Education

- Assessment and Evaluation
- Telephone Support
- Crisis Intervention
- Critical Incident Debriefing
- Information and Referrals
- Follow-up Services
- Safety Planning
- Consultation Services
- Prevention and Postvention

***Crisis Intervention Teams (CIT)***

CIT is a best practice designed to provide law enforcement agencies with training on resources to connect persons in a mental health/substance use crisis to community supports and services. It is also a partnership between local police and community mental health/substance use services to jointly respond to crises when appropriate. The goal of CIT is to reduce the need for arrest in favor of referrals to appropriate treatment resources and supports and to promote safety for persons in crisis, the community and the police. Every mobile crisis team has CIT trained clinicians who work collaboratively with law enforcement, providing mental health evaluation and recommendations when responding to crisis calls. The CT Alliance to Benefit Law Enforcement (CABLE) is the organization responsible for providing basic and advanced CIT training in the State of Connecticut to law enforcement officers and mental health professionals. CIT training emphasizes person-centered, recovery-oriented approaches and interventions and prepares law enforcement personnel to recognize and respond to various mental health and addiction crises, including trauma. It also emphasizes ways to develop effective communication and connection skills and strategies for police officers to work with mobile crisis team clinicians who follow up on calls to offer supports and services to individuals in distress.

***Mobile Crisis Response Learning Collaborative (MCRLC)***

The DMHAS Mobile Crisis Response Learning Collaborative (MCRLC) began in March 2020 with a full day kick-off event hosted at the Connecticut Women's Consortium in Hamden, CT. Over 100 mobile crisis team directors, managers and staff attended. The state-operated and private non-profit mobile crisis team providers continue to meet on the first Wednesday of each month. The MCRLC Planning Committee meets periodically to discuss topics of interest, identify presenters and best practices and develop meeting agendas. CIT trained officers and clinicians join the MCRLC quarterly to focus on conversations specific to law enforcement and crisis services.

***ACTION line (Adult Crisis Telephone Intervention and Options Network)***

The United Way of Connecticut (UWC)is a National Suicide Prevention Lifeline (NSPL) provider that maintains national accreditations from the Alliance for Information and Referral Services (AIRS) and the American Association of Suicidology (AAS).

DMHAS, in partnership with UWC, established the Adult Telephone Intervention and Options Network (ACTION) line for adults 18 years of age or older who are in the community and in the midst of a psychiatric or emotional crisis for which an immediate response may be required. The ACTION line is a centralized phone number (1-800-HOPE-135 or 211) answered by staff trained to offer an array of supports and options to individuals in distress, including telephonic support, referrals and information about community resources and services; warm-transfer to the Mobile Crisis Team (MCT) of their area; and when necessary, direct connection to 911. The direct phone numbers to each of the mobile crisis teams are still functional and available, offering "no wrong door" access to crisis services.

The ACTION line operates 24 hours a day, seven days a week, 365 days a year (24/7/365) with the availability of multilingual staff or interpreters as needed. The centralized line is available to provide after-hours telephonic coverage for mobile crisis providers throughout the state. The services and supports offered through the ACTION line are available to all residents of Connecticut at no financial cost to the caller. The ACTION line team is comprised of dedicated contact specialists, licensed clinicians and a peer support specialist with lived mental health and substance use/addiction experience. The DMHAS mobile crisis teams and ACTION Line staff work in collaboration with family members, peer-run organizations, faith-based communities, law enforcement, and other civic and community organizations to ensure those persons in distress and their families/friends/supporters have the support and resources they need within their local community.

## II. 988 Implementation and Impact on Service System

In 2017, the National Suicide Hotline Improvement Act (H.R. 2345) was introduced to the U.S. House of Representatives to request a new, national, 3-digit dialing code to direct callers to the National Suicide Prevention Lifeline. This charged the Federal Communications Commission (FCC) to determine how or if this could be done. In 2019, the FCC officially recommended the switch to the 3-digit dialing code of 988, resulting in the Act becoming law in May of 2020.

In July of 2022, the National Suicide Prevention Lifeline will officially change from 1-800-273-8255 to the three-digit dialing code of 988. One of the main goals of this shift is to reduce the stigma associated with mental health; the idea being that no one is embarrassed to call 911 for an emergency, so no one should be embarrassed to call 988 for a mental health emergency. In addition to reducing stigma, it is also expected that making a nationally recognized and easy to remember 3-digit number like 911 will increase the ease and accessibility of help for those experiencing a behavioral health crisis. This transition is also designed to have more behavioral health crisis calls directed to the Lifeline (988) rather than 911, since Lifeline call centers have advanced training and experience specific to behavioral health crises.

If the above assumptions hold true (to reduce stigma and to increase ease and access to behavioral health support), it is expected that Connecticut will see a significant increase in the volume of

behavioral health calls. Therefore, it is critical that DMHAS have the resources available to offer a full continuum of crisis services and supports to individuals experiencing a mental health and/or substance use crisis.

## III. Description of Current Mobile Crisis Service System

### A. State-Operated Mobile Crisis Services (by facility):

The following table describes our *current* State-operated mobile crisis services, which currently only has one site with 24/7 mobile crisis coverage. A total of 35 state-operated positions are in the process of being recruited to expand these services, which is described in another chart later in this report.

| State Operated LMHA | Annual DMHAS Funding | DMHAS Funded Staffing | Hours of Operation | Comments |
|---|---|---|---|---|
| Capitol Region Mental Health Center (CRMHC) Hartford | $909,038 | 8 | Mon-Sun 8:00am-12:00am (7 days a week) | With additional DMHAS funding, CRMHC expanded their hours into 2nd shift as of 6/4/21. |
| Connecticut Mental Health Center (CMHC) New Haven | $593,445 | 5 | 24/7* | CCBHC Grant funding was awarded to CommuniCare to provide after-hours mobile crisis coverage for CMHC |
| River Valley Services (RVS) Middletown | $1,103,045 | 13 | Every day (including holidays) 8:00am – 12:30am | Also provides after hours mobile crisis coverage for Rushford daily M-F 4:00pm – 10:00pm, Sat/Sun 12:00pm – 8:00pm (including holidays) |
| Southeastern Mental Health Authority (SMHA) Norwich | $1,145,223 | 12 | Every day (including holidays) 8:00am – 12:30am | |
| Southwest Community Mental Health System (SWCMHS) Bridgeport, Stamford | $488,031 | 6 | M-F 8:00am – 4:30pm | |
| Western Connecticut Mental Health Network (WCMHN) Torrington | $709,632 | 11 | Every day (including holidays) 8:00am – 12:00am | |
| Western Connecticut Mental Health Network (WCMHN) Waterbury | $601,725 | 7 | Every day (including holidays) 8:00am – 12:00am | |

*Note: CMHC provides mobile crisis services M-F 8:30am – 5:00pm. CommuniCare is a consortium of providers which includes two Local Mental Health Authorities (BHCare and Bridges) as well as South Central Crisis Services (SCCS), the after-hours provider of telephonic and mobile crisis services to people in the greater New Haven area. SCCS also provides after-hours coverage for CMHC. While mobile crisis services are available 24/7, there is only one FTE from CommuniCare providing mobile crisis services after hours to several providers (BHCare Shoreline, BHCare Valley, Bridges, and CMHC), which is not adequate coverage. DMHAS is discussing additional expansion of these services with both CommuniCare and CMHC.

## B. Private Non-Profit Mobile Crisis Services (by facility):

The following table describes *current* private non-profit mobile crisis services. These providers are in the process of using new dollars to expand their mobile coverage to 24/7 and that is described in another chart later in this report.

| Private Non-Profit LMHA | Annual DMHAS Funding | DMHAS Funded Staffing | Hours of Operation | Comments |
|---|---|---|---|---|
| BHCare (Shoreline & Valley) Branford, Ansonia | *See CommuniCare | 1 | M-F 8:30am – 5:00pm | After hours, weekend and holiday coverage provided by CommuniCare's South Central Crisis Services |
| Bridges Milford | *See CommuniCare | 1 | M-F 8:30am – 5:00pm | After hours, weekend and holiday coverage provided by CommuniCare's South Central Crisis Services |
| CommuniCare | $873,524 | 5 | M-Th 5:00pm – 8:30am Fri. 5:00pm – Mon. 8:30am | Through South Central Crisis Services, provides after hours coverage for BHCare, Bridges, and CMHC with 1 FTE per shift. |
| Community Mental Health Affiliates (CMHA) New Britain | $846,310 | 6 | M-F 8-8:00pm Sat & Sun 10:00am-3:00pm Holidays 9:00am-6:00pm | |
| Community Health Resources (CHR) Enfield, Manchester | $446,888 | 6 | M-F 9am-10pm Sat & Sun 10:00am-8:00pm Holidays 10:00am-8:00pm | |
| Danbury Hospital (Nuvance Health) | $713,771 | 10 | M-F 7am-10pm Sat & Sun 7:00am-10:00pm Holidays 7:00-10:00pm | |
| InterCommunity (IC) East Hartford | $222,592 | 5 | **For IC clients:** 24/7 **For all other citizens:** M-F 8am-7pm | |
| Rushford Meriden | $246,862 | 3 | M-F 8:00am–4:00pm | River Valley Services provides mobile crisis coverage daily M-F 4:00pm – 10:00pm, Sat/Sun 12:00pm – 8:00pm (including holidays) |
| United Services, Inc. (USI) Northeast | $801,629 | 8 | M-F 9:00am –7:00pm | |

## C. Crisis Respite Programs (by region and provider):

As mentioned previously, the DMHAS continuum of crisis care currently consists of mobile crisis teams (providing both in-person and telephonic support), a statewide crisis call line - ACTION Line (providing telephonic support and warm handoff to a mobile crisis team/clinician if needed), crisis respite beds, and assessment for referral to the system of care. Historically, crisis respite beds are in high demand, limited in number, and difficult to access when needed in a crisis situation. DMHAS is currently examining and evaluating crisis respite programs to ensure that parameters such as lengths of stay, admission, and discharge criteria are being met, so these programs are readily accessible as an alternative to the emergency department for individuals in crisis.

### Region 1: Total Beds = 13

| Program | Location | Capacity | Average LOS for FY '21 |
|---|---|---|---|
| Continuum of Care Crisis Respite | Bridgeport | 10 | 16.02 days |
| Inspirica Gilead Jail Diversion Respite | Stamford | 3 | 172 days |

### Region 2: Total Beds = 37

| Program | Location | Capacity | Average LOS for FY '21 |
|---|---|---|---|
| Continuum of Care ASIST Crisis Respite | New Haven | 1 | 207.33 days |
| Continuum of Care Crisis Respite | New Haven | 9 | 12.03 days |
| Continuum of Care Jail Diversion Respite | New Haven | 1 | 11.46 days |
| Continuum of Care YAS Crisis Respite | New Haven | 1 | 20.25 days |
| River Valley Services Crisis Respite | Middletown | 8 | 27.02 days |
| Rushford Crisis Respite | Meriden | 10 | 18.70 days |
| Yale New Haven Hospital Crisis Respite | New Haven | 7 | 12.52 days |

### Region 3: Total Beds = 15

| Program | Location | Capacity | Average LOS for FY '21 |
|---|---|---|---|
| SMHA Brief Care Unit | Norwich | 15 | 82.85 days |

### Region 4: Total Beds = 20

| Program | Location | Capacity | Average LOS for FY '21 |
|---|---|---|---|
| CHR Enfield Crisis Respite | Enfield | 6 | 204.5 days |
| CMHA Crisis Respite | New Britain | 4 | 70.22 days |
| Mercy Crisis Respite | Hartford | 10 | 146.14 days |

### Region 5: Total Beds = 15

| Program | Location | Capacity | Average LOS for FY '21 |
|---|---|---|---|
| WCMHN Crisis Respite | Waterbury | 8 | 158.33 days |
| WCMHN Jail Diversion Crisis Respite | Waterbury | 4 | 103.71 days |
| WCMHN YAS Crisis Respite | Waterbury | 3 | |

## IV. Description of Future Mobile Crisis Service System

DMHAS is committed to expanding mobile crisis services to be able to provide mobile, in-person crisis response 24 hours a day, 7 days a week, 365 days a year. The charts below describe how each Local Mental Health Authority (LMHA) is enhancing staffing and expanding hours of operation for SFY22. All of the state-operated LMHAs submitted budgets that were approved for additional staffing that will allow them to offer mobile crisis services 24/7. Their plans for expansion are outlined below.

### A. State Operated LMHA Plans for expansion to 24/7 (by facility):

| LMHA | #/Type of Positions Requested | Notes/Comments | 24/7 with new positions? Yes or No |
|---|---|---|---|
| **CMHC New Haven** | None | Currently South Central Crisis Services (SCCS) provides after hours coverage for CMHC, Bridges, BHCare Shoreline and BHCare Valley with only one clinician for all of these providers. Question if this is adequate staffing given large geographic area. CMHC's mobile crisis clinicians also have other duties such as intake evaluations, triage, and follow-ups. | YES |
| **CRMHC Hartford** | **1st shift**<br>1 MH Assistant 2<br>**2nd shift**<br>1 Supervising Clinician<br>**3rd shift**<br>1 Supervising Clinician<br>2 LCSW Associates | Minimum staffing on each shift is 3 people, regardless of job title. | YES |
| **RVS Middletown** | 3 Full-time Licensed Clinical Social Worker Associates<br>1 Part-time Licensed Clinical Social Worker Associate<br>1 Advanced Practice Registered Nurse<br>1 LCSW | There is currently a staff shortage on first and second shift of Licensed Clinical Social Workers and supervisors. Will need to replace these positions first before moving on to hire 3rd shift staff.<br>Mobile crisis clinicians also provide clinical support and oversight to RVS's crisis respite program. | YES |
| **SMHA Southeast** | 6 LCSWAs (for 3rd shift) | *Licensed Clinical Social Worker Associates on first shift also conduct intakes and support outpatient teams in non-crisis interventions. | YES |
| **SWCMHS** | 12 LCSWAs | | YES |
| **WCMHN** | **Torrington:** 2 LCSWAs for 3rd shift**,** 2 RSSs<br>Waterbury: 2 LCSWAs for 3rd shift; 2 RSSs | *Have weekend day (1st shift) and evening (2nd shift) coverage currently – 3 staff each shift.<br>**Maintain at least one Licensed Clinical Social Worker Associate on each shift | YES |

**B. Private Non-profit LMHA Plans for expansion to 24/7 (by facility):**

This fiscal year, DMHAS was allocated an additional $2.5M in legislatively appropriated annualized funding to expand mobile crisis services. DMHAS has determined the appropriate algorithm for allocation of these funds to seven current mobile crisis providers. Factors considered in the development of the algorithm include:

- Current DMHAS funding for mobile crisis services,
- Geographic area served by the provider (both square miles and general population size of individuals age 18 and older),
- Total number of individuals served by the provider,
- Total number of individuals served by each provider's mobile crisis team.

Based upon these factors, each provider was "ranked" in each of these areas, then provided with an average rating. This rating was used to ensure the potential distribution of the funds was consistent with the ranking order. DMHAS conducted meetings with each provider to discuss how the additional funding would be used to expand their mobile crisis services. The table below summarizes their plans for expansion.

| LMHA | Additional Funding (annualized) | New Total Funding (current + new) | Plans for Expansion | 24/7 with new dollars? Yes or No |
|---|---|---|---|---|
| CommuniCare (BHCare, Bridges, South Central Crisis Services) Branford, Ansonia | $468,750 | $1,342,274 | TBD | YES |
| Community Mental Health Affiliates (CMHA) New Britain | $399,306 | $1,245,616 | CMHA plans to expand their current hours of operation, especially on weekends, to offer more coverage for mobile crisis services. They would also like to expand their Crisis Intervention Team (CIT) program by adding an additional FTE clinician who would work collaboratively with the police departments in their catchment area. | NO |
| Community Health Resources (CHR) Enfield, Manchester | $538,194 | $985,082 | With the additional funding, CHR will be able to offer mobile crisis services 24/7 and plans to hire 2.5 FTEs to add a third shift to their program. | YES |
| Danbury Hospital (Nuvance Health) | $260,417 | $974,188 | Danbury Hospital plans to hire two additional FTE staff to provide mobile crisis services during the overnight hours (11pm-7am) | YES |

| LMHA | Additional Funding (annualized) | New Total Funding (current + new) | Plans for Expansion | 24/7 with new dollars? Yes or No |
|---|---|---|---|---|
| InterCommunity (IC)<br>East Hartford | $295,139 | $517,731 | Using this additional funding, IC will be able to provide 24/7 mobile crisis support to *all* citizens in their catchment area (not just current individuals receiving services from IC). | YES |
| Rushford<br>Meriden | $190,972 | $437,834 | Rushford plans to continue to utilize RVS for after-hours coverage, M-F 4:00pm – 10:00pm, Sat/Sun 12:00pm – 8:00pm (RVS is in agreement with this). They will use the additional funding to add a third shift position which will be embedded in the Meriden Police Department. Funding will not be adequate to provide full 24/7 coverage; would possibly have 1 FTE M-F 10:00pm – 8:00am or daily from 10:00pm – 6:00am. Rushford is working with Meriden PD to determine highest need/volume days/times. | NO |
| United Services, Inc. (USI)<br>Northeast | $347,222 | $1,148,851 | TBD | NO |

## V. Future Considerations

### A. Funding needed for expansion

As referenced in the charts above, many of DMHAS's mobile crisis teams will be able to achieve 24/7 mobile response however there are still a few that will be unable to meet that goal without additional fiscal resources.

The American Rescue Plan Act of 2021 (ARP) amended Title XIX of the Social Security Act (the Act) by adding new section 1947 "State Option to Provide Qualifying Community-Based Mobile Crisis Intervention Services." Section 1947(e) authorizes CMS to make funding available for implementing and administering, and to make planning grants available to states to prepare for implementing qualifying community-based mobile crisis intervention services.

Qualifying community-based mobile crisis intervention services, as defined at section 1947 of the Act includes, "items and services for which medical assistance is available under the state plan under this title or a waiver of such plan that are furnished to an individual, otherwise eligible for medical assistance, who is outside of a hospital or other facility setting; and experiencing a mental health or substance use disorder crisis."

States that submit and have approved by CMS, SPAs, section 1915(b) waiver programs with a corresponding authority for the services at issue, section 1915(c) home and community-based

services waiver programs, or section 1115 demonstration applications meeting the conditions for the state option, may receive an 85 percent federal medical assistance percentage (FMAP) for expenditures on qualifying community-based mobile crisis intervention services, and for services furnished by qualifying mobile crisis intervention service providers, for the first 12 quarters within the five-year period beginning April 1, 2022, during which the state meets the conditions for the 85 percent FMAP. Further, section 1947 requires that for any quarter for which the 85 percent FMAP rate is claimed, states provide assurances satisfactory to the Secretary that any additional federal funds received by the state for qualifying community-based mobile crisis intervention services that are attributable to the increased FMAP under this section will be used to supplement, and not supplant, the level of state funds expended for such services in the federal fiscal year prior to April 2022, or the federal fiscal year prior to the first quarter that the state takes up this option.

Through the additional fiscal resources made available by this Medicaid match, there is the potential to continue to expand crisis services statewide.

Where is the mention Medicaid Coverage option in April 2022 and enhanced Medicaid match under ARPA and thus the possibility for additional resources to expand services?

**B. Other considerations**

Providers noted that significant statewide shortages of behavioral health clinicians may hinder expansion of licensed clinical staff. The providers referenced the possibility of amending CT CGA 17a-503-d to include Licensed Professional Counselor as a behavioral health professional able to execute emergency certificates could be part of the solution to this challenge on mobile crisis teams. It should be noted that all providers expressed significant challenges with the ability to hire staff, particularly licensed clinicians, across the service system. They are experiencing additional challenges in hiring staff to work in mobile crisis during the evening and overnight hours.

# RFP 21PSX0042
# Department of Mental Health and Addiction Services, Electronic Health Records Request for Proposals Questionnaire

1) Business Information (Proposer Profile, Experience and References)

A. Background and Financial Information:

1. Company Name and Geography
2. Address of company headquarters
3. Year the Company Was Established
4. Significant Company Merges, Acquisitions, and Sell-offs
5. Public or Private Ownership Model
6. Any Bankruptcy/Legal Issues (including under which name the bankruptcy was filed and when, or any pertinent lawsuits, closed or pending, filed against the company.)
7. Research and Development Investment (expressed in a total amount or percentage of total sales)
8. Statement of Key Differentiators: The vendor should provide a statement describing what differentiates its products and services from those of its competitors.

B. Client base for EHR proposed to DMHAS. (for the purpose of this section, a "client" is defined as a Behavioral Health System or Facility)

| Category | Response |
|---|---|
| EHR Name Proposed for DMHAS | |
| Number of Behavioral Heath Clients LIVE on solution | |
| Number of concurrent end users at peak times | |

C) Three Behavioral Health references utilizing the software product you are proposing to DMHAS of similar size and nature

1. New client with less than 1 year on system
2. Established client with more than 3 years on system

2) Applications

A) Provide technology specifications that support the product (e.g., database, architecture, operating system, browser, etc.).

B) Describe the options for remote-hosting the product or if the product Software-as-a-service.

C) Describe how the product supports remote access for workers not on-site or not physically connected to the DMHAS network.

D) This RFP is specific to use at DMHAS, however the option to extend its use to other state agencies is a future possibility. Describe how the product would partition/ separate or isolate each agency's data so they are not accessed or shared either by users or by system administrators.

E) Complete the following table about the applications for the proposed product for DMHAS and installed at customer sites. The vendor MUST identify when a third-party product is being proposed. Identify/provide the total Behavioral Health sites installed per application.

| APPLICATION FUNCTION | NAME OF PRODUCT | TOTAL CLIENT INSTALLS | CURRENT RELEASE |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

As rows as needed

3) Functional Capabilities

Please answer the Yes/No Questions AND provide any correlating comments on the included Excel worksheet - DMHAS_RFP EHR Functionality.

4) Implementation Model

A) Provide a description of the implementation plan for the proposed products and/or services that specifically describes the overall implementation approach of your system.

B) Provide your estimated implementation timeline for the proposed products and services.

C) Provide a staffing plan for the implementation of the proposed EHR product for DMHAS, including the recommended number of DMHAS dedicated staff by skill set that will be required to implement all products proposed for the stated scope.

D) Provide a vendor staffing implementation plan for the applications proposed including the approximate number of vendor staff that will be assigned to this implementation. Identify the staff that will be dedicated full-time throughout the lifecycle of the implementation versus staff that would offer interim support as needed. Include any Technical services and Conversion services provided.

E) Describe any training services provided by vendor staff. Please list training manuals, reference guides, on-line help by subject, content sensitive help, etc. Identify the format as hard-copy print, on-line printable, or on-line content sensitive

F) Describe any pre-go-live services provided such as comprehensive workflow analysis, recommendations for configurations, table set-ups, and historical data migration.

5) Maintenance and Support

A) Identify DMHAS IS staffing requirements to support the system post go-live, with all vendor-proposed applications installed.

B) Describe your post implementation support structure, including Help Desk support and hours of support. Include the tiers of support provided as well as the process to request enhancements or new features.

C) Provide your proposed production service level agreements (SLA's) including, but not limited to average response times, average resolution times, Mean Time Between Failures, RTO, RPO, system availability, etc. If SLA's differ between applications, please note differences.

D) Describe your version control process including new release timelines, client testing requirements, training, etc.; The process to patch, upgrade, and/or migrate to new releases should require minimal time, effort, and downtime.

E) Please list all current product certifications (CCHIT, MIPS/MACRA, Cures Act, etc.) related to this product and confirm that you will keep your product current in all required governmental certifications as part of the normal annual maintenance costs.

F) Describe how your product will help CT-DMHAS maintain required certifications and audits, including The Joint Commission (TJC), the Centers for Medicare and Medicaid (CMS) and others.

G) Provide a copy of the warranty describing how it is affected by maintenance and support agreements after the implementation period.

H) Do you have an active online support community of other users like us?

6) Security

A) What security certifications do you possess?

1. When was your last audit?
2. How often do you get audited?
3. Can you confirm compliance with HIPAA Privacy and Security Rules?

B) How is the data protected?

1. Administrative – Policies and Procedures
2. Physical – Data Center Controls
3. Technical – Technology solutions used to support policies and procedures

i. Access Control

ii. Unique User Identification

iii. Emergency Access

iv. Encryption

v. Audit Controls

vi. Integrity

vii. Transmission Security

viii. Backup

ix. Disaster Recovery

C) Describe all backup and recovery procedures, including who performs them.

D) How many tiers of security are available?

E) Detail how your organization would respond to a data security breach.

F) Do you maintain a well-document security infrastructure?

G) Detail the level of auditing that is available and what access the customer has to audit logs. How are these logs accessible to staff that need them?

H) Describe any use of incident protection and detection software.

I) Describe your ability to use encrypted data storage and transmission while compensating for performance implications.

J) Do you maintain infrastructure standards certification like International Standards Organization/International Electrical Commission (ISO/IEC 27002)?

K) Please provide an estimated response time from support personnel when contacted regarding security issues.

L) Can our data be moved among multiple data centers? If so, how are we notified?

M) Will you allow for the storage of a customer's data outside the United States of America?

N) Do you provide for the delegation of user provisioning administration to the customer?

O) Can you provide written copies of your security and privacy policies and procedures including disaster recovery?

P) Are you insured to cover the costs of recovery from a security breach? Please provide limitations and exclusions of coverage

## 7) Cost Estimates and Value

Responses should be based on not-to-exceed estimates inclusive of itemized Software Application purchases, Services, Hardware, and Hosting as well at time and materials)

The cost response must clearly separate one-time costs, implementation/installation costs, and recurring costs for a minimum of five years.

Costs for each component and service should be broken down between installation and ongoing expenses.

A timeline to implement a new EHR may include a 'Big Bang' or phased approach by DMHAS facility. However, if there is a difference in cost, please include that in the following cost estimate information.

A) Unit cost for all license types for all required software elements, including improving economics as volume changes.

B) Unit cost for all services elements, so that individual SOWs can be priced easily, including improving economics as volume changes.

C) Integration costs to interface the following applications with the new EHR:

- CORE-CT (Peoplesoft) - Connecticut state government's integrated human resources, payroll, and financial System. Interface would supply employee information to the EHR for role-based security management.
- Billing Control System (BCS) – provided by DMHAS Information Systems Department is an application solution that processes the PNP and EHR encounter (claims) data for billing to the Department of Administrative Services (DAS), the billing agent for DMHAS.
- Enterprise Data Warehouse (EDW) – Nightly batch process that will receive data from the new EHR. Data collected includes Client Demographics, Admission, Diagnosis, Assessment, Service and Discharge information.
- CBORD – Nutrition services application.
- Pyxis – Medication dispensing.

D) Expected costs related to data migration from legacy systems and data stores. This cost should be estimated based on 3 primary legacy systems and many Excel and MS-Access based data stores. Please provide a process and vendor cost associated with a 'typical' migration from these sources so DMHAS can understand likely costs given associated volume of migration sources.

E) Remote hosting costs for all proposed applications, by fiscal year, including planned or expected pricing increases.

F) Total estimated costs, by State fiscal year (assuming [What Date?] project kickoff), including detailed build up to the total (unit costs, number of units, effective dates of any subscription step-ups, software and services elements separate, etc.).

G) Demonstrated alignment between step-ups in subscription costs to delivery of new services and functionality (not paying for software that is not providing value to taxpayers).

H) Maximum allowable annual price increases for the duration of the contract term.

I) Submit all (if any) price assumptions, conditions, or exceptions.

J) Explanation to support the correlation between the proposed pricing and the proposed technical approach.