TRANSFORMING CHILDREN'S BEHAVIORAL HEALTH POLICY AND PLANNING COMMITTEE

YOUTH JUSTICE INSTITUTE
University of New Haven

TCB PRESENTATION HIGHLIGHTS

September 2023 – March 2024

Contents

Executive Summary

Introduction:

The Transforming Children's Behavioral Health Policy and Planning Committee (TCB) convened six meetings between September 2023 and March 2024. These meetings addressed critical issues within Connecticut's children's behavioral health landscape, including urgent crisis centers, the continuum of care, insurance coverage, and services for specific populations.

Objective:

This Executive Summary condenses key challenges and recommendations identified by stakeholders during TCB meetings held from September 2023 to March 2024. The report also incorporates updates based on feedback provided by presenters following those meetings, collected between March 30 and April 5, 2024.Stakeholders from various backgrounds, including state agencies, non-profit providers, parents and other stakeholders involved in children's behavioral health system, presented and identified several critical challenges. These themes will inform workgroup discussions, guide future planning, and build upon previous work.

For a deeper understanding of each presentation topic, including specific challenges, recommendations, and any relevant updates, please refer to the dedicated sections within this report using the provided **Contents** table.

Common Themes:

Sustainable Funding Model: The current Medicaid rates and grants often fall short of covering essential service costs. This hinders recruitment, infrastructure maintenance, competitive wages, and service expansion, ultimately impacting care quality. Clinics face a substantial funding shortfall, sparking fierce competition for resources from private grants, fundraising, and donations. Securing grants is hindered by a very difficult application process, yielding a 25% success rate for non-profits. This, coupled with the need to hire a dedicated staff to manage fund development, creates a substantial financial burden on financial strain budgets.

Strengthening the Behavioral Health Workforce: Low wages, stress, and burnout contribute to staff retention challenges. This turnover strains resources and impacts care continuity.

Data and Information Sharing: Inconsistent data collection methods across providers create challenges in assessing the prevalence, monitoring progress, and ensuring accountability. This hinders efficient resource allocation and targeted program design.

Delivery of Services: Demand for intermediate care (extended day programs, intensive home-based services) exceeds provider capacity, leading to referral bottlenecks and delayed access to essential services.

Access and Equity in Service: Geographic isolation and limited number of providers restrict access in rural or underserved areas. Medicaid's in-person service limitation hinders flexibility and reach, especially for families with

transportation challenges. Inadequate insurance coverage, high deductibles, and out-of-pocket expenses further limit access.

Including Family and Caregiver Support: Limited family-based treatment options, reimbursement challenges, and a complex system can leave families struggling to access care. Family Peer Support and dedicated care coordination can be invaluable for navigating the system and advocating for their child's needs.

Recommendations:

- Address funding models to ensure sustainable service delivery, including competitive wages and infrastructure support.
- Implement strategies to address workforce shortages, such as loan repayment programs and career development initiatives.
- Establish standardized data collection methods for comprehensive needs assessment, progress monitoring, and improved service planning.
- Expand capacity for intermediate care services to address referral bottlenecks and improve access.
- Address access disparities by advocating for policy changes that promote insurance equity (including Medicaid) and address transportation barriers.
- Prioritize family-based, needs-based approaches by creating funding models that support family training, consultations, and service code expansion to reflect holistic care models.
- Establish consistent age-related service access and discharge criteria across state agencies.
- Expand access to comprehensive care coordination services for families, with a sustainable funding mechanism.

Conclusion:

This summary provides insight into the significant hurdles and suggestions highlighted by stakeholders during recent TCB meetings. Collaboration among policymakers, providers, and community organizations is imperative to tackle these challenges effectively. By enacting the recommended measures, we can strive towards a children's behavioral health system in Connecticut that is more accessible, equitable, and efficient.

The updates provided by the presenters underscore the ongoing need for concerted efforts to improve children's behavioral health services. Many of them have stated that the challenges continue to exist, and some have worsened since their initial discussion at the TCB meeting. The full report provides detailed information on the specific challenges, recommendations, and updates from presenters.

Thank You: We extend our sincere gratitude to all the providers and state agencies who shared their valuable insights and updates as of March 2024. Recordings of each meeting topic are accessible through hyperlinked references within each section of the report. The presentations and supplementary materials shared during the meeting can be accessed on the TCB page of the Connecticut General Assembly website.

Urgent Crisis Centers (September 2023)

Presenters:
Department of Children and Families
Wellmore Behavioral Health
The Village for Families and Children
Child and Family Agency of Southeastern CT
Yale New Haven Hospital

The September TCB meeting centered on Urgent Crisis Centers (UCCs). The Department of Children and Families (DCF) provided background on their creation, prompted by the Children's Behavioral Health Plan (2014)[1]. This plan identified high youth use of emergency departments (EDs) for mental health needs and called for alternative options like crisis stabilization centers. The need for alternatives was further emphasized by the Children's Behavioral Health Urgent Care and Crisis Stabilization Unit Workgroup (2021), highlighting the strain on ED resources. In response, UCCs were established across Connecticut, operated by organizations like The Village for Families and Children, Wellmore Behavioral Health, Child and Family Agency of Southeastern CT (CFA) and Yale New Haven Hospital.

Representatives from the UCCs highlighted the services provided. UCCs are walk-in clinics located across Connecticut that provide same-day crisis assessment and intervention for youth in a safe, non-emergency room environment. UCCs divert youth from overwhelmed emergency departments by providing a more appropriate setting for mental health crisis intervention. UCCs create a supportive environment with family involvement in assessment, planning and follow-up, while utilizing research-backed approaches to address underlying needs. Although valuable, the TCB meeting discussion also highlighted challenges and recommendations for improvement.

Key Challenges:

- Uncertain Funding: Unstable funding threatens service disruptions and hinders UCCs' ability to meet community needs.
- Reimbursement issues: Current funding models (Medicaid, fee-for-service) may not adequately support UCC operations.
- Insurance Coverage Gaps: Gaps in insurance coverage, particularly for those with private insurance, limit access for some youth.
- Difficulty Retaining Staff: Competitive salaries and high demand make it difficult to retain qualified staff, impacting the consistency of care. UCCs require at least three skilled professionals per shift, and they often rely on temporary workers (per diem) to fill staffing gaps.
- Limited access to follow-up care creates bottlenecks: High demand for services like extended day programs and in-home support outpaces provider capacity. This results in backlogs, delaying connection to appropriate resources for youth after UCC intervention. Staffing shortages across care levels further strain UCCs and slow down service delivery for families.

[1] TCB UCC Presentation Link: https://www.youtube.com/live/yHnkt5n-8a8?si=aEvOxIsodFO_cIPy&t=3316

- Limited Public Awareness of UCCs: Many families are unaware of UCCs, a critical resource for youth in crisis.
- Transportation: Limited transportation options can create barriers for families seeking UCC services, with a significant portion (30%) arriving by ambulance, particularly from schools. However, Medicaid ambulance rates not being established, created an additional financial hurdle.

Recommendations:

- Addressing Insurance Gaps: Encourage commercial insurance plans to cover UCCs services and establish billing mechanisms to address disparity and ensure equitable access for all.
- Sustainable Funding: Secure continued state funding and explore additional revenue streams to ensure UCCs' long-term viability.
- Investment Needed for Long-Term Effectiveness: Data shows similar crisis programs required 2 years to reach full capacity. UCCs anticipate a similar timeframe, emphasizing the importance of ongoing state support to maximize their impact.
- Strengthen Referral Networks: Collaboration with Schools and Mobile Crisis Teams: Promote communication and collaboration with local schools and crisis teams to encourage referrals to UCCs as an alternative to emergency departments.
- Rural access: Ensuring strong connections to UCC care for families in rural communities.
- Public Awareness Campaigns: Increase funding for public awareness campaigns to educate families about UCCs and their services.
- Addressing transportation barriers: Investigate options to improve access to UCCs for families facing transportation challenges (e.g., ambulance rates)

Updates from UCCs:

- Since opening, the three-community based UCCs have served 820 clients in their first nine months (UCC Update, 04/01/2024).
- Across the three providers, UCCs successfully diverted 94% of clients served by the Child and Family Agency (CFA), 98% served by The Village, and 95% served by Wellmore, from emergency departments. All clients received comprehensive safety plans and detailed aftercare plans with referrals.
- UCCs are experiencing a surge in utilization, with a 70% increase in clients served during the most recent six weeks compared to the prior six-week period (FY 2025 Funding Request for Community Urgent Crisis Centers: Connecticut's Response to the Child Mental Health Crisis). This trend is expected to continue as we enter spring and summer, which historically see the highest demand for children's behavioral health crisis services.
- Wellmore Behavioral Health: Now offers 24/7 service after successfully filling overnight staffing positions.
- The Village for Families and Children: Expanding to weekend hours, with hiring currently underway.
- CFA: Maintains weekday evening hours (10 pm to closing) and Saturday hours (10 pm to 6 pm).
- UCCs are actively building their per diem staff to guarantee comprehensive coverage for absences, including vacations, personal days, sick leave, and extended leaves like maternity leave.

- Medicaid codes for UCC services are now active (April 1, 2024). These codes allow for reimbursement of approximately $500 per client.

Updates from DCF:

- The Medicaid State Plan was amended, effective April 1, 2024, to introduce specialized billing codes for UCCs.
- The three community UCCs (Wellmore Behavioral Health, The Village for Families and Children and CFA) have been certified as UCC program for Medicaid. The Yale New Haven Hospital Program will be operating as part of the Yale New Haven Hospital Emergency Department.
- The Department of Public Health (DPH) has implemented guidance for ambulances to divert youth from ED to UCCs, if medically appropriate. The Department of Social Services (DSS) has issued a provider bulletin confirming Medicaid reimbursement for emergency ambulance transport to UCCs.
- A grant from SAMHSA has been awarded to implement a Performance Improvement Center for UCCs. CHDI will oversee this initiative, providing quality assurance and data reporting services to enhance UCC effectiveness.
- DCF provided data on utilization trends across various UCC functions, including number of episodes, insurance type of youth served, gender identity of youth served, race/ ethnicity served, age of youth served, referral source, presenting concern, length of stay and discharge (**Refer to Addendum: UCC Data Summary)**

Accessing the Continuum of Care: Outpatient Services (November 2023)

Presenters:
LifeBridge Community Services
Child Health and Development Institute (CHDI)
Mid-Fairfield Community Care Center
Community Health Resources

The November presentation "Accessing Continuum of Care: Outpatient Services in Connecticut" highlighted the importance of outpatient mental health care services for children.[2] The presentation featured insights from organizations like LifeBridge Community Services, Mid-Fairfield Community Care Center and Community Health Resources. CHDI provided a clear picture of the state's outpatient landscape. These services, including therapy and medication management, are essential for children's behavioral health. While numerous providers exist, including state-funded clinics, the exact number remains unclear. These clinics offer effective, evidence-based treatments that reduce disparities in care compared to traditional approaches. However, despite their effectiveness, access to these services remains a significant challenge.

Key Challenges:

- Workforce Shortages and Low Wages: Limited resources and competitive market dynamics are hindering workforce recruitment and retention, particularly for Spanish-speaking clinicians. This trend incentivizes clinicians to pursue opportunities in private practice or telehealth settings, further constraining service capacity. The resulting shortage of qualified professionals equipped to address the growing demand and complexity of cases disrupts care continuity due to high staff turnover. Additionally, nonprofits face funding shortfalls, leading to staff cuts despite rising demand for services.
- Workforce and Enhance Care Clinics (ECCs) Protocols: While ECC status eliminates waitlists, ongoing workforce shortages, largely due to funding limitations, create a burden on remaining staff. Continuing to meet access standards without waitlists necessitates absorbing additional caseloads when staff leave, potentially leading to further strain on existing personnel.
- Low Medicaid Reimbursement Rates and Flat-Funded Grants: Current Medicaid rates and grants are insufficient to cover the full cost of service delivery. Furthermore, the lack of dedicated state funding for pre-service activities like initial screenings, scheduling appointments, and navigating the system for families creates a significant barrier to access, especially for those unfamiliar with the children's behavioral health system.
- Funding to Replace ARPA funds: Previously available American Rescue Plan Act (ARPA) funds designated for mental health services will no longer be accessible. This creates a potential funding gap that could impact the ability to maintain current service levels.

[2] TCB Accessing Continuum of Care: Outpatient Services Meeting Link: https://www.youtube.com/live/oznjjb0OBAc?si=aXyglxrtb8wd9KXD&t=2093

- Telehealth Limitations: Medicaid currently only reimburses for in-person services, limiting the reach and flexibility of care delivery. This limitation may pose challenges for families facing transportation difficulties or seeking geographically convenient options.
- Limited Data and Accountability: Inconsistent data collection hinders efforts to assess the problem's scope, track progress, and ensure accountability. This limits effective resource allocation and program development.
- Surge in Demand and Severity: Rise in the number of low-income clients without insurance seeking mental health services. Also, there has been a concerning increase in mental health presentations among younger children, including self-harm, PTSD, anxiety, and depression. These trends are placing a strain on existing resources. Effectively addressing these complex needs often requires specialized interventions such as EMDR and DBT-Child. However, the implementation and maintenance of such Evidence-Based Practices (EBPs) can be costly, potentially limiting access for some children.
- Financial Barriers: Inadequate insurance coverage, high deductibles, and out-of-pocket costs create financial barriers for families seeking mental health services. Additionally, the lack of Medicaid reimbursement for pre-service support hinders families' ability to navigate the system and access initial care.
- Unmet Basic Needs: Difficulty meeting basic needs, such as food and housing security, can significantly impact a family's ability to prioritize and engage with mental health services. Addressing these fundamental needs is essential for establishing a foundation for mental well-being.

Recommendations:

- Increase Funding: Increase funding allocations to existing outpatient clinics while conducting a comprehensive review of Medicaid and private insurance reimbursement rates. Funding models should integrate inflationary adjustments to ensure long-term service sustainability, quality care delivery through qualified personnel and evidence-based practices, and adequate staffing levels to meet patient needs.
- Strengthen Workforce: Implement programs to attract and retain qualified mental health professionals, with a focus on recruiting bilingual clinicians. Additionally, enhance compensation packages to make outpatient clinic positions competitive with private practice options.
- Improve Data Collection: Establish consistent data collection procedures across all mental health providers. This standardized approach will facilitate the creation of a comprehensive data set encompassing service utilization, client needs, and treatment outcomes. This comprehensive data set will be instrumental in informing effective resource allocation, program development, and the implementation of robust accountability measures.
- Reduce Administrative Burdens: Identify and eliminate administrative procedures deemed unnecessary, focusing on those that consume time and resources. Additionally, streamline existing processes to improve overall efficiency and alleviate administrative burdens for both mental health providers and families seeking care.
- Expand Telehealth Options: Current Medicaid restrictions require either the clinician or the client to be physically present in the facility, limiting the ability to utilize telehealth services. However, this model would necessitate on-site staff to greet clients, manage the therapy room, set up technology, and provide technical support during sessions. Flexible telehealth regulations would assist in hiring a qualified Spanish-speaking clinician from out-of-state (who will obtain CT licensure) to provide remote video sessions.

- Address Equity: Adopt a reimbursement model based on patient complexity (similar to CMS' Case Mix Index). This approach aligns reimbursement with the actual needs of patients, ensuring fair compensation for providers serving high-needs communities and managing complex cases.
- School-Based Services: Allow outpatient clinics to provide counseling services in schools to reduce access barriers for children and families. Bringing services closer to students can encourage early intervention and normalize mental health care.
- Develop Specialized Programs: Allocate funding and support the expansion of specialized evidence-based interventions like EMDR and DBT-Child to address the growing need for treatment of complex mental health issues among younger children.

Updates from Presenters:

Despite the absence of progress on previously outlined recommendations, stakeholders uniformly highlighted the ongoing need to address critical issues within the children's outpatient mental health system. These concerns, if anything, have worsened since the last presentation. Stakeholders agree that addressing existing funding issues is crucial before considering service expansion.

- The recent rate study data provides stronger evidence for inadequate Medicaid reimbursement.
- An influx of referrals from schools is straining service capacity due to workforce shortages.
- ARPA funding allocated for mental health services will no longer be available next year.
- Clinics are experiencing a significant funding gap of approximately 35%. This necessitates intense competition for scarce resources from private grants, fundraising initiatives, and individual donations. However, securing grant funding presents a challenge due to the time-consuming and resource-intensive application process, with a success rate of only around 25% for non-profit organizations. This low success rate, coupled with the need for additional staff to manage applications, further exacerbates the financial burden on already strained budgets.

Medicaid Coverage for Children's Behavioral Health Services: Payment Policies (December 2023)

Presenters:
Department of Social Services

Representatives from the Department of Social Services (DSS) presented on Medicaid sustainability efforts. [3]The collaborative effort between DSS, Department of Mental Health and Addiction Services (DMHAS), and Department of Children and Families (DCF) through the Connecticut Behavioral Health Partnership (CTBHP) to enhance access, expand services, and improve Medicaid payment development. As the largest payer of children's behavioral health services, Medicaid covers various levels of care and plays a crucial role in the provider network and payment rates. The presentation objectively outlined Medicaid's comprehensive range of covered services and various initiatives to enhance access to mental health services. Pending initiatives were discussed, including establishing UCCs and ongoing Medicaid rate studies. The study aims to enable a comprehensive analysis of all rates across the Medicaid program, which can then inform coordinated decisions regarding potential investments of the state's limited resources. Insights into trends in pediatric psychiatric services were provided, emphasizing efforts to reduce readmission rates and improve discharge processes. Future steps involve completing rate study analysis, collaborating with stakeholders, and addressing system issues and service gaps.

Recommendations

- Update of Billing Codes: DSS proposes using the following billing codes for UCCs:
    - Nurse triage
    - Nurse assessment
    - Psychiatric evaluation
    - Crisis codes
- Monitor for Improvement: Continue to monitor system issues and address service gaps.
- Address Payment Model: Implement a value-based payment model to ensure access, improve quality, and promote equity in outpatient service delivery.

Updates from Department of Social Services:

- Medicaid Rate Study completed phase 1 of the study, and phase 2 is underway.
- A $5 million allocation has been designated to raise behavioral health provider rates. The specific distribution plan for clinics and private practitioners is still under development.
- Rates for critical behavioral health services will be increased, with the specific methodology to be determined.
- DSS has met with stakeholders to solicit feedback.
- CCMC opened the inpatient psychiatric unit with admissions having begun. The unit is gradually increasing its patient population.

[3] TCB Medicaid Coverage for Children's Behavioral Health Services Meeting link: https://www.youtube.com/live/BwYmZ292RhI?si=ZcFJ9NqhOGlxevJ4&t=511

- Workforce shortages and long waitlists continue to restrict access to in-home-based services. Additionally, psychiatric residential treatment facilities (PRTF), particularly for girls, remain a challenge.

Sustainability Efforts through Commercial Insurance (January 2024)

Presenters
Anthem Blue Cross Blue Shield
Carelon Behavioral Health

Representatives from Anthem Blue Cross Blue Shield and Carelon Behavioral Health Services presented in the January 2024 TCB meeting. [4]Carelon Behavioral Health, formerly known as Beacon Health Options, plays a crucial role in Connecticut's behavioral health and insurance landscape, serving as the Administrative Service Organization (ASO) for mental health, behavioral health, and substance use services under Medicaid. Collaborating with the Department of Children and Families (DCF), the Department of Social Services (DSS), and the Department of Mental Health and Addiction Services (DMHAS), the ASO manages Medicaid and community services, impacting over 900,000 individuals. The Carelon Behavioral Health Commercial Division, independent from CTBHP and Child and Family Divisions, leads as the Behavioral Health clinical and network lead for Anthem Blue Cross and Blue Shield in Connecticut. Staff, leadership, and resources in this division are distinct and separate.

Diversified Insurance coverage:

- Insurance coverage in Connecticut includes Self-Insured (37%), Medicaid (26%), Medicare (19%), Large Group – Fully-Insured (7%), Uninsured (5%), Small Group—Fully-Insured (3%), and Individual—Fully-Insured (3%). Within the Commercial Market, the majority are self-insured (74%), followed by Large Group—Fully-Insured (15%), Individual—Fully-Insured (6%), and Small Group—Fully-Insured (5%).

Carelon – Urgent Crisis Care Center

Carelon has been implementing a new level of care, urgent care, for children with complex needs. Anthem is a collaborator on this project. There are two main areas of focus.

1. Consistent coding needs to be established to collect accurate data. Medicaid finalizing its codes is awaited.
2. A different reimbursement model beyond fee-for-service is being discussed. A case rate of 90 days (about 3 months) was proposed to better reflect the complex and time-consuming nature of the service.

Recommendations:

- Collaboration among Medicaid, commercial insurers, and providers to develop a sustainable reimbursement model for urgent care services.
- Provider meeting to discuss expectations and needs.

[4] TCB Substainability Efforts through Commerical Insurance Meeting link:
https://www.youtube.com/live/Nm5TuHmEJY8?si=X644KV75Nczg7vmX&t=694

- Learning collaboratives to educate the public about appropriate utilization of urgent care services.
- Looking to Massachusetts for best practices, as they are ahead of Connecticut in implementing urgent care for behavioral health.

  No updates have been provided.

Accessing the Continuum of Care: Intensive Home-Based Services (January 2024)

Presenters:
Yale IICAPS
Wheeler Clinic
The Child & Family Guidance Center
Carelon Behavioral Health

The January 2024 TCB presentation highlighted the history and evolution of children's behavioral health care in Connecticut.[5] The state has implemented community-based treatments for diverse needs, aligning with national priorities of early detection, access, evidence-based practices, and strengthening families collaboratively. The presentation focused on four specific evidence based Intensive Home-Based programs: Multi-Dimensional Family Therapy (MDFT), Multisystemic Therapy (MST), Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS), and Functional Family Therapy (FFT). Each program demonstrated effectiveness in reducing substance use, improving family relationships, and decreasing hospital admissions. Presenters highlighted the broader child mental health crisis strains resources, and urgent legislative support is needed.

Key Challenges

- Increase demand and declining capacity: Connecticut families grapple with rising anxiety, depression, and isolation in their children, who already face increasingly complex mental health needs. This surge in demand for intensive in-home therapy overwhelms limited resources.
- Workforce Shortage and Burnout: Stagnant Medicaid reimbursement rates and inadequate grant funding impact the ability to attract and retain qualified staff. The continuous effort dedicated to therapist recruitment, while potentially resulting in new hires, adds to the stress experienced by existing staff. This creates a cycle wherein clinicians often enter and exit positions. Consequently, well-trained professionals often leave for higher-paying and less stressful opportunities, taking their valuable skill sets. This perpetual cycle heightens the risk of burnout and exacerbates the exodus from the field. Lower retention rates lead to increased training costs and diminish the overall clinical skill level within the workforce, ultimately compromising the quality of mental health services provided.
- Funding shortfalls: Commercial insurance often excludes in-home therapy, further restricted by denied coverage. Inadequate grant funding perpetuates the struggle to maintain quality care. These funding shortfalls disproportionately harm vulnerable youth, increasing their risk of behavioral health problems and emergency room visits.

[5] TCB Accessing the Continuum of Care: In-Home Services Meeting Link: https://www.youtube.com/live/Nm5TuHmEJY8?si=sbZqu9Tk-k219z38&t=3742

Recommendations:

- Increase Medicaid reimbursement rates: This will allow agencies to offer competitive salaries, attract qualified therapists, retain staff expertise, and incentivize clinicians to serve this population.
- Restore or increase grant funding: This will improve operational efficiency and service capacity in understaffed programs, ensuring they can meet the needs of children and families.
- Mandate in-home family therapy coverage by commercial insurers: This will expand access to equitable care for all Connecticut's children who require this vital service.

Updates from Presenters

Unresolved challenges continue to strain Connecticut's robust behavioral health system, designed to address diverse needs.

- The proposed budget for FY25 did not include COLA for providers of intensive in-home services.
- Many commercial insurance plans continue to exclude in-home service delivery, forcing providers to make difficult decisions about continuing delivery of certain programs.
- Staffing shortages persist at most FFT sites, hindering their ability to reach full capacity.
- IICAPS's current waitlist is approaching 600, with a 4-6 month wait in some areas. There are 55 open positions across the network**.**
- Multiple IICAPS site closures have occurred throughout recent years, including 2011, 2022, and 2023. These disruptions have significantly impacted service capacity with an anticipated closure at the end of fiscal year 2024. The number of families served annually has declined. Pre-pandemic, IICAPS served approximately 2,000 families each year. This number dropped to about 1,300 in fiscal year 2023 and is expected to decline to around 1,000 by the end of fiscal year 2024.
- The Department of Children and Families (DCF) currently does not offer grant funding to support activities related to expanding the IICAPS network, including onboarding new sites, training staff, and data management.
- Three agencies have shown interest in joining the IICAPS network. However, due to limitations in existing grant support, replicating the program to accommodate these agencies is not currently feasible.

Landscape of Early Childhood Services: OEC (February 2024)

Presenter:
Office of Early Childhood (OEC)

The Office of Early Childhood (OEC) provided background history and landscape of services offered to improve the early childhood services[6]. Prior to 2013, navigating early childhood support programs required accessing resources spread across multiple agencies. Recognizing this challenge, the OEC was established in 2013. This centralized hub streamlined service delivery, allowing the OEC to effectively prioritize the diverse needs of families and ensure equitable access to programs for all children.

The OEC oversees a robust network of impactful initiatives proven to contribute to children and families' well-being. These initiatives include Home Visiting, Birth to Three, Head Start, and Early Head Start. Beyond program oversight, the OEC actively spearheads vital behavioral health initiatives such as the Early Childhood Consultation Partnership (ECCP) and collaborations with the Connecticut Association of Infant Mental Health (CT-AIMH). The OEC reported funding allocations for behavioral health services at $15,211,136. This allocation includes $7,635,848 of stable, ongoing core funding, and the remaining funding comes from a variety of sources, including grants and time-limited federal dollars. The OEC emphasizes a comprehensive approach to preventing mental health challenges in children and families. This approach utilizes a three-tiered model of interventions:

- **Primary Prevention:** Focuses on promoting mental well-being and preventing the onset of mental health problems.
- **Secondary Prevention:** Aims to identify and address early signs of mental health concerns to mitigate their impact.
- **Tertiary Prevention:** Provides support and treatment for individuals already experiencing mental illness, promoting recovery and preventing further complications.

The OEC recognized supporting mental and behavioral health as a lifelong process that extends beyond services provided during a child's early years.

Recommendations:

- Invest in a well-coordinated continuum of care: This ensures seamless support for children and families as their needs evolve.
- Build strong partnerships with sister agencies: Collaboration across agencies creates a comprehensive and effective support system throughout a child's life.

[6] TCB Landscape of Early Childhood Services: OEC
https://www.youtube.com/live/_F75lgQ_ZX8?si=mgTRpXzIJ6s9Rlm-&t=1788

Updates by OEC:

- Stigma around mental health, resource access and family involvement remain a challenge, however, growing awareness is a positive step.
- OEC's statewide behavioral health awareness campaign, developed in partnership with Odonnell Company, is approved and set to launch in early April 2024. (TCB Request for Written Update in prep for April 3rd TCB Meeting – provided by OEC)
- Highlighting services from sister agencies remains a priority to create a comprehensive support system.
- OEC highlighted continued effort to spreading awareness throughout the state by sharing various resources such as crisis intervention phone numbers, support for families in acute needs, connections to mental health professionals and community-based support and resources for families with high risk.
- OEC leverages monthly webinars to raise awareness about their behavioral health initiatives. These webinars are accessible to the public and recordings are available on the OEC website under the "Behavioral Health Initiative" section.
    - February 27th: "Nurturing the Nurturer: A Guide to Parental Self-Care"
    - March 19th: "Women in Business in CT: A Reflection of the Past and a Look Ahead" (featuring remarks by Lt. Governor Susan Bysiewicz)

Landscape of Early Childhood Services: DCF (February 2024)

Presenter

Department of Children and Families

A representative from the Department of Children and Families (DCF) highlighted its critical role in supporting early childhood services.[7] DCF collaborates closely with the Office of Early Childhood (OEC) to prioritize children's social, emotional, and developmental well-being within the caregiver relationship. Key initiatives include the Early Childhood Consultation Partnership (ECCP®), an evidence-based program providing mental health consultation in early care or education settings. ECCP® aims to enhance caregivers' capacity at individual, family, classroom, or center-wide levels, promoting optimal outcomes for young children. Additionally, DCF offers Parenting Support Services (PSS), delivering interventions such as Level 4 Triple P (Positive Parenting Program®) and Circle of Security Parenting© to families with children aged 0-18 years. Collaborations with Advanced Behavioral Health (ABH) and the Connecticut Association for Infant Mental Health (CT-AIMH) provide intensive support, while the Child First program offers comprehensive, home-based services for families facing complex challenges.

No updates were provided.

[7] TCB Landscape of Early Childhood Services DCF Meeting Link: https://www.youtube.com/live/_F75lgQ_ZX8?si=vvh5UthulDuOkGrM&t=3390

The Trauma of Homelessness: The Impact on Very Young Children & Families (February 2024)

Presenter

Ed Advance

Through a strong partnership with the Torrington Public School District, Ed Advance's grant-funded Homeless Outreach Coordinator works directly with school social workers and community providers to support the unique and varied needs of children and youth experiencing homelessness, so they come to school ready to learn.[8] The program is designed to build on the normalcy and stability of the school environment to overcome barriers to educational engagement. In addition, the Homeless Outreach Coordinator partners with area school districts to ensure compliance with the McKinney-Vento Homeless Assistance Act.

Trauma of Homelessness: Children's physiological well-being, brain architecture, and mental health are all significantly impacted by early and ongoing exposure to poverty-related stressors, which can lead to physical and psychological difficulties that last a lifetime. Remarkably, the majority of people who become homeless in the United States do so during their early years; in fact, almost half of the kids in HUD shelters are younger than six. Numerous challenges that homeless children must overcome, such as poor nutrition, irregular sleep schedules, delayed growth, and subpar academic performance, increase their susceptibility to toxic stress and complex trauma.

Key Challenges:

- Impact of Homelessness on Pregnancy: The effect of homelessness on pregnancy: After giving birth, mothers who are released from the hospital are returned to these shelters, where they are exposed to environments that are not ideal for their premature development. Prenatal care is not given to these mothers.
- Challenge in the developmental stages of children: The precarious living conditions, lack of resources to fulfill basic needs, and exposure to harsh environments all impede the crucial developmental phases of children. The inadequate infrastructure, marked by poor maintenance and safety hazards, poses additional risks.
- Emotional constraints on the parents: Families residing in overcrowded shelters contend with managing behavioral issues and power struggles, adding to parental stress. Moreover, parents often feel scrutinized by others, leading to embarrassment and pressure regarding their parenting approach. In 2023, there were instances of families with young children residing in cars, highlighting the urgent need for improved support and resources.
- Impact on the Preschoolers: Unstructured preschools with limited resources can trigger a cycle of problems. Children with weak foundational learning may struggle with behavior, leading to housing instability for families. Stressed parents, lacking positive coping mechanisms, might unintentionally worsen the cycle, creating tension within the community.

[8] Trauma of Homelessness: Impact on Very Young Children & Families Meeting Link: https://www.youtube.com/live/_F75lgQ_ZX8?si=7iTuRho4IX_sHU2d&t=3866

Recommendations:

- Connect families with support: Connect families with housing support, McKinney Vento liaisons, and early care and education programs especially Head Start, School Readiness, and other federally and state-funded programs such as OEC, DCF, and CT – AIMH
- Integrate social determinants of health: Integrate social determinants of health into mental health efforts for these young children., by increasing screening in the shelters, and providing training to the providers.

Updates from Ed Advance:

- The key challenges stated above continue to exist.
- There has been some movement at the state level to the commitment to helping young families experiencing homelessness, for example, access to federal housing vouchers.

Child First Model (February 2024)

Presenter
Child First Model Developer

Child First is an intensive, evidence-based, two-generation, home-based intervention that serves young children and families experiencing trauma and adversity.[9] It works with a community's most vulnerable young children (prenatal to age six years) and their families. The goal is to identify children in high-stress environments or with signs of distress at the earliest possible time and intervene to decrease emotional and behavioral problems, developmental and learning problems, and abuse and neglect.

Key Challenges:

- Lack of access to services: Insufficient provision of mental health services for young children and families, particularly in Intermediate clinic-based and Intensive home-based treatments, is leading to heightened demand for extensive interventions to address escalating mental health issues.
- The closure of 21 Child First services, which previously catered to nearly 500 families, exacerbates this gap in support.
- Pediatric Primary Care is not well utilized as a valuable source of both primary prevention, early intervention, identification, and referral.
- Web-based Service Inventories are very confusing for both parents and professionals and rarely include services for young children.
- The lack of a comprehensive continuum of care for young children with social emotional/mental health difficulties and their families is needed.
- Funding: Multiple federal funding streams (and commercial insurance) are not being well utilized for early childhood mental health.
- There is a need for greater focus on the Social Determinants of Health (SDoH) and their impact on the emotional, mental, and relational health of young children.

Recommendations:

- Social Determinants of Health: Integrate the Social Determinants of Health into prevention and identification efforts.
- Increase access to services:
    - Increasing funding for young children who have suffered trauma and their families.
    - Incorporate services at the intermediate level.
    - Make use of outpatient environments for young children by guaranteeing Medicaid reimbursement (less than four years) and giving staff members more early childhood mental health training.
    - Utilize Medicaid reimbursement to meet the present demand for Child First services (and retain highly skilled staff).

[9] TCB Early Interventions for Lasting Impact Meeting Link:
https://www.youtube.com/live/_F75lgQ_ZX8?si=_mNlt_nXfyjYiai2&t=1029

    - Revise web-based mental health inventories from the perspective of the parents/caregivers.
    - Training: Research, evaluate, and implement strategies used nationally and in Connecticut.
- Funding
    - Leverage all possible federal funding streams for future mental health services for young children and families. After Medicaid is established, access Commercial insurance.
    - Access funding for Care Coordinators, Community Health Workers, Health Navigators, and Doulas.

Updates

The suggestions put forth by the presenter underscore the significance of passing HB 5454, titled "An Act Concerning Mental Health Services for Young Children and Their Caregivers" (Refer to Addendum) as it addresses several challenges and recommendations outlined in the February 2024 TCB Meeting. (Update received as of 3/31/24)

1. Lack of services for young children and families who need mental health who intervention, especially Intermediate level (clinic-based) and Intensive Home-Based Treatment. HB 5454 calls for steps to maximize federal resources for mental health services for young children, their caregivers and pregnant people. This would address the current, critical need for critical need for Child First services (given the expected closure of almost 40% of CT services). It would also open the possibility to look broadly at mental health services for young children, (which would include outpatient services for children under 4 years).

3. A comprehensive continuum of care for young children with social-emotional/mental health difficulties and their families is needed. HB 5454 calls for the development of a strategic plan by DSS, in collaboration with OEC, DCF, DMHAS, and ideally DPH, to optimize federal and state resources for mental health services for children under six, their caregivers, and pregnant individuals. The plan aims to create a unified approach to early childhood mental health care, integrating various services funded by Connecticut departments. This initiative seeks to establish a continuum of personalized, relationship-centered services, matching each family's unique needs. Additionally, it advocates for data analysis to identify gaps, improve outcomes, and enhance service delivery for children and families with social-emotional needs.

4. Multiple federal funding streams (and commercial insurance) are not being well utilized for early childhood mental health. HB 5454 aims to utilize existing federal and state funds, such as Medicaid, TANF, and federal grants, to provide mental health services, including Child First, to children facing abuse, neglect, developmental delays, or relationship disruptions, without needing a formal diagnosis. This expansion ensures timely and effective intervention for emotional, behavioral, and relational challenges in young children, improving outcomes and accessibility to treatment.

5. HB 5454 mandates submitting a strategic plan report to the General Assembly by October 1, 2024. The report would include recommendations for funding early childhood mental health services for children up to age six, caregivers, and pregnant individuals. This would prepare for appropriate funding of early childhood mental health services in the next budget cycle (FY26-FY27). This will be essential to prevent future closures of Child First sites (and other services), with loss of critical services for those young children and families who need them most.

OHS Study of Payment Parity and Behavioral Health Coverage by Private Insurers (March 2024)

Presenters:
Acumen
Office of Health Strategy (OHS)

The Office of Health Strategy and Acumen LLC presented results to Parity Study for the TCB March meeting.[10] The Connecticut Office of Health Strategy (OHS), in partnership with Acumen, LLC, conducted a thorough study under Public Act 22-47, subsections 57 and 58. This study encompassed two primary components: the Behavioral Health Coverage by Private Insurers Study and the Payment Parity Study. While the Behavioral Health Coverage Study scrutinized reimbursement rates offered by health carriers for a range of services, including physical, mental, and substance use disorder treatments, the Payment Parity Study delved into payment parity between providers of mental health/substance use disorder services and those of other medical services. Despite Connecticut's robust behavioral health workforce, ranking third in the New England region, challenges persist. Data from the U.S. Bureau of Labor Statistics underscored the state's competitive salaries for various positions within the behavioral health sector. Disparities in reimbursement rates between HUSKY (Medicaid) and private insurance for certain behavioral health services were identified, alongside concerns regarding payment parity for specific insurance programs. The Department of Labor conducts a Warning Signs Analysis to ensure alignment with the Mental Health Parity and Addiction Equity Act (MHPAEA) and the Patient Protection and Affordable Care Act (ACA). The report revealed that HUSKY reimbursement rates fell below the benchmark across all behavioral health and general medical services. It's crucial to recognize the study's constraints, notably its exclusive reliance on medical claims data, which necessitates a deeper exploration of potential parity concerns. The study's scope is confined to medical claims data from the All-Payer Claims Database (APCD), omitting other vital state funding sources and payments for services billed by facilities. Additionally, it overlooks funding from state-operated facilities or mobile crisis units, focusing solely on payments to individual practitioners, thereby excluding payments billed by facilities or licensed behavioral health clinics. These limitations underscore the necessity for a more comprehensive approach to fully understand and address payment parity issues in behavioral health services.

Key Challenges

- Low Medicaid Rates Discourage Participation: Behavioral health providers participate less frequently Across all insurance types. A significant factor, especially for Medicaid, is the issue of low reimbursement rates for services.

[10] TCB OHS Report on Payment Parity and Behavioral Health Coverage by Private Insurers Meeting Link: https://www.youtube.com/live/VFa8JTKF8JM?si=OpdbmzHVtxonAMUy&t=1084

- Studies on Temporary Fee Increases: While temporary Medicaid fee increases for primary care, mandated by the ACA, led to improved appointment availability for existing Medicaid enrollees, the impact on attracting new providers was limited. Existing doctors saw more Medicaid patients, but the study found no significant increase in the overall number of providers accepting Medicaid.
- Studies have shown that independent of the ACA temporary fee adjustment, Medicaid fee increases have led to heightened healthcare utilization and enhanced access for beneficiaries seeking Medicaid-accepting providers.
- HUSKY shows lower reimbursement rates compared to the benchmark across BH and general medical services but no specific concerns regarding BH payment parity.
- Medicare Advantage exhibits lower ratios for BH services than general medical services, indicating potential lack of parity; The ratios for MA psychiatrists and neurologists are lower than rates for other physician specialties suggesting that physician-provided BH services are not in parity with physician-provided general medical services.
- Private Insurance issuers:
    - Three issuers in the state have rates near the benchmark or higher for nearly all services. BH services have ratios that are in a similar range as the ratios for general medical services. There are no parity concerns for these issuers.
    - Four issuers have a preponderance of ratios for BH services that are lower than the benchmark, including several BH services that are less than 90 percent of the benchmark.
    - In contrast, most ratios for general medical services are near or above the benchmark.
    - The results for these issuers suggest potential parity concerns and warrant further investigation.

Recommendations

- Strategies to address workforce shortages include:
    - Peer Support Services – those who have successfully recovered from a mental health or substance use disorder can obtain certification to provide support to those experiencing similar conditions.
    - Inter-State Licensing – allows qualifying providers to practice in participating states without obtaining additional licensure.
    - School-Based Health Care – improve care access, prevent unnecessary emergency department visits, and reduce depressive episodes/suicide risk for adolescents.
    - Crisis Care – Enhance crisis care networks and services for individuals experiencing psychiatric or substance abuse-related emergencies who require immediate care.
- Efforts to attract and retain mental health workers involve increasing residency spots and offering loan forgiveness, financial incentives, and mentorship programs.

No updates provided.

Home and Community Supports Waiver for Persons with Autism (March 2024)

Presenter:
Department of Social Services

A representative from the Department of Social Services ASD Waiver Division presented on the ASD Waiver.[11] The Lifespan Waiver, also known as the Home and Community Supports Waiver for Persons with Autism, is managed by the Department of Social Services specifically to individuals with autism who do not have an intellectual disability, as evidenced by a full IQ score of 70 or higher, meeting specific criteria. To qualify, individuals must show substantial limitations in two or more major life activities (e.g. Self-care, language comprehension and use and mobility). This waiver offers a broad range of home and community-based services tailored to those with autism, including behavioral support, job coaching, mentorship, life skills training, respite care, assistive technology, and more. There are caps and allotments for active participants, with a maximum waiver cap of $50,000 per person annually with the average allotment in CY 2023 amounting to $25,498. The program has grown over the years, with the addition of 13 new providers in CY 2023, bringing the total number of providers to 151. Since transitioning from DDS to DSS in 2016, the waiver has expanded significantly, with an increase from 3 case managers and 120 individuals receiving waiver services to 11 case managers and 330 individuals either being determined Medicaid eligible or receiving waiver services. Despite program growth and provider expansion, there's still a significant demand, as evidenced by a lengthy waitlist of 2,058 individuals, highlighting the ongoing need for such services and the importance of continued program support and expansion.

Key Challenges:

- Waitlist: 2,058 individuals seeking services as of February 16, 2024, with 120 more cases expected in July 2024, highlighting high demand and limited capacity.
- Eligibility criteria may exclude some individuals who could benefit from the program, potentially leaving gaps in service coverage.
- Funding constraints evident by the maximum waiver cap of $50,000 per person per year, potentially limiting the scope and depth of services provided.

Recommendations:

- Advocate for increased funding to raise the maximum waiver cap, allowing for more comprehensive and sustained participant support.
- Streamline administrative processes and increase resources to reduce the waitlist and improve access to services for individuals with autism.
- Invest in workforce development to train more professionals capable of providing specialized support and services to individuals with autism, thereby increasing capacity to meet demand.

[11] https://www.youtube.com/live/VFa8JTKF8JM?si=cJl_t13QxbI9HoOY&t=4639

Updates from DSS ASD waiver division:

- The waiver participants have an average allocation of $27,000.
- Due to the effort of filling newly available waiver slots, changing the funding structure to a 2-tier system is not recommended currently.
- As an alternative, the program suggests adding essential services for participants within the existing $50,000 funding cap. Examples include on-call support and group employment services.
- DSS ASD waiver division conducts on going contact with members on the waitlist in the form of regular request for demographics updates.
- Of the 261 people removed from the waitlist since FY 2022 65 or %24 either declined services, moved out of state, are on a different waiver, were referred back to DDS, or could not be located.
- Between CY 2022-2023, Demographic update mailings identified 78 individuals removed from the waiting list due to moving out of state, deceased, or already DDS/ID eligible.
- The current intern is contacting qualified providers from existing Medicaid waiver programs to explore participation in the ASD Waiver program.
- While the ASD Waiver Division cannot directly assess waitlist needs or provide emergency services, the resource list (**Refer to Addendum: List of Resources provided by the DSS Autism Waiver Division)** aims to connect with potential sources of assistance.

Barriers to Care for Children and Families Living with Neurodevelopmental Disorders (March 2024)

Presenters:
The Center for Children with Special Needs
Clifford Beers Community Health Partners

The March presentation focused on the significant challenges faced by families with children with neurodevelopmental disorders (NDDs) with a focus on autism spectrum disorder (ASD). These challenges disproportionately impact families in underserved communities. The panel proposed a series of challenges and solutions aimed at creating a more supportive system for children with NDDs and their families. These solutions centered around a family-centered care approach, targeted outreach programs, and addressing logistical barriers.

Key Challenges

- Disparities in Diagnosis and Access: Disadvantaged families, especially in Black and Brown communities and underserved areas, face delayed ASD diagnosis due to limited specialists. This creates *"service deserts*" and hinders access to care, impacting children's long-term outcomes. Even where services exist, logistical challenges, such as transportation, work schedules, and language barriers, further hinder access to care.
- Diagnosis Delays: The current reliance on a diagnostic-based medical model can result in extended wait times for diagnosis. This delay can significantly impact children's access to critical services and interventions during critical developmental periods.
- Inconsistent Age Requirements: Discrepancies among state agencies regarding age requirements for access/discharge from services create confusion, complicated transitions, and disproportionately impact families with fewer advantages. Federal law mandates educational support for individuals identified with ASD up to age 22, exacerbating the issue.
- Family Support Issues: The current system lacks support structures for families, including insufficient family-based treatment options and inadequate reimbursement for these services.
- Limited Crisis Care Options: Limited access to appropriate crisis care for individuals with ASD due to geographic limitations, staff expertise, bed availability, and lack of community awareness strains families alongside overwhelmed emergency departments not equipped for such cases.
- Connecticut Faces Group Home Crisis: Shortage of group homes licensed by Department of Developmental Services (DDS) for children with ASD I/DD who also present behavioral challenges. This shortage is worsened by closures of existing group homes and restrictions on admissions to community living arrangements (CLAs).
- Lack of Care Coordination Services Available: The lack of essential care coordination services creates a significant barrier to delivering comprehensive care. These services, including assistance with program enrollment, school contracts, securing recreational activities, and navigating medical needs, are crucial for supporting families and clinicians.
- Limited Employment Opportunities for ASD individuals: Inclusive employment initiatives in CT are limited for ASD individuals who possess academic and intellectual capacities; however, they require social and

communication support. Restrictive access requirements limit workforce inclusion by creating high barriers to entry.

- Workforce Shortages: Limited training programs at various education levels for ASD and neurodevelopmental disorder practitioners contribute to workforce shortages. This results in long wait times for diagnosis and treatment, with uneven access to providers across regions.
- Reimbursement Challenges: Inadequate Medicaid and commercial reimbursement rates restrict access to services for individuals with neurodevelopmental disorders, creating a fragmented system and negatively impacting service outcomes.
- Licensure requirements: CT DSS Medicaid currently sets stricter mandates for behavioral technicians than most commercial carriers. This significant difference creates challenges in finding qualified candidates, leading to shortages of qualified personnel and reducing access to essential care for children on Medicaid.

Recommendations

- Standard Age Guidelines: Standardize ASD service access and discharge at age 22 across state agencies. This will reduce confusion, streamline support for young adults with ASD, and align with federal education mandates.
- Targeted Outreach and Education: Implement targeted outreach programs, particularly in underserved communities, to raise awareness of ASD and the available support services.
- Addressing Access Barriers: Develop solutions to address common access barriers faced by families, such as transportation, employment scheduling conflicts, and language barriers.
- Funding for Family-Centered Care: Expand access to services by implementing funding streams prioritizing family-focused, needs-based approaches.
- Develop New Service Codes and Increase Reimbursement Rates: Creating specific billing codes for family consultations, training, and wraparound care coordination services (including navigating DSS applications, program identification, and school communication), alongside raising Medicaid and commercial insurance rates to reflect the actual cost of care, will incentivize providers to offer these crucial supports. This will empower families, alleviate clinician burden, and ultimately lead to better long-term outcomes.
- Reduce Clinician Burden through Dedicated Professionals: By enabling dedicated care coordination professionals to handle wraparound services, we can alleviate clinicians' workloads, allowing them to focus on providing direct care to patients.
- Comprehensive Crisis Care and Support Services: Investment in specialized crisis care facilities equipped to handle such episodes, along with an expansion of inpatient beds for children and adults requiring this level of care. This will be complemented by enhanced outpatient and in-home services to provide ongoing support and interventions, ultimately reducing reliance on crisis care admissions.
- Adjustment to Behavioral Technicians standards: To ensure consistency and reduce workforce recruitment barriers, Medicaid standards and commercial insurance requirements should align.
- Address ASD/NDD workforce shortage with a multi-pronged approach: expand training programs (community colleges, undergrad/grad) and offer incentives (loan forgiveness, scholarships, professional development) to attract and retain practitioners. Prioritize funding for this critical initiative.
- Solutions to Employment Barriers for individuals with ASD: Promote inclusive employment and remove access barriers for individuals with ASD and NDDs. This includes developing and implementing comprehensive employment initiatives tailored to their needs, such as social and communication support.

Additionally, we advocate for eliminating restrictive access requirements imposed by CT state agencies, fostering a more inclusive environment for these individuals to enter the workforce.

- Addressing Closure Impact: Secure alternative placements for boys displaced by the imminent closure of a group home. To prevent future disparities, advocate for increased funding to establish new group homes specifically designed for boys with ASD/IDD and behavioral challenges. This will ensure equitable access to appropriate residential care options across genders.
- Mitigating Waitlist Concerns: Alleviate the waitlist for placements at Adelbrook, provider for girls with ASD / IDD by expediating adult placement processes for individuals turning 22 years old, freeing up spaces for new admissions.
- Parent Advocacy Engagement: Use a parent voice affected by the closure of group homes to share their story to raise awareness and advocate for solutions.

No updates were provided.

Addendum

UCC Data Summary: Opening – 12/31/23 Provided by DCF on April 1, 2024

This section provides a detailed breakdown of UCC utilization data for End of calendar year. The data presented here reflects utilization trends across various UCC functions, including ***number of episodes, insurance type of youth served, gender identity of youth served, race/ ethnicity served, age of youth served, referral source, presenting concern, length of stay and discharge.***

Number of Episodes

The three community-based UCCs had a total of 436 episodes of care, ranging from 116 (CFA) to 182 (The Village).

CFA	The Village	Wellmore	Total		Yale
116	182	138	436		751

Insurance Type of Youth Served

Across the three community-based UCCs, 59% of youth served by UCCs have HUSKY insurance. Most other youth served were covered by private insurance.

	CFA	The Village	Wellmore	Total		Yale
Husky	55%	53%	67%	59%		72%
Commercial/Private	37%	43%	27%	37%		27%
Primary Private and Secondary Husky	4%		5%	3%		
Self-Pay	3%		1%	1%		1%

Gender Identity of Youth Served

Across the three community-based UCCs, there was a slightly higher percentage of female youth served than male youth. Four percent of youth served identified as trans or non-binary, but this data was only reported by two providers.

	CFA	The Village	Wellmore	Total		Yale
Female	52%	50%	45%	49%		52%
Male	40%	50%	49%	47%		48%
Trans or Non-Binary	9%		7%	4%		

Race/Ethnicity of Youth Served

Across the three community-based UCCs, White youth are the largest group of youth served (54%). These three UCCs saw Hispanic youth at a slightly lower rate than the CT population.

	CFA	The Village	Wellmore	Total	CT Population		Yale
Black/African American	7%	14%	14%	12%	11%		27%
White/Caucasian	66%	45%	56%	54%	50%		37%
Hispanic	15%	25%	22%	21%	26%		30%
Another Race	6%	0%	5%	3%	6%		5%
Multi-racial	5%	0%	2%	2%	7%		0%

Age of Youth Served

The majority of youth served by the three community-based UCCs (79%) were between ages 10 and 18.

	CFA	The Village	Wellmore	Total		Yale
0-5	3.40%	4%	7%	5%		1%
6-9	13.80%	17%	16%	16%		14%
10-13	30.20%	33%	36%	33%		50%
14-18	52.60%	46%	42%	46%		35%

Referral Source

Referral sources varied significantly by provider. Across the three community-based UCCs, referrals were most likely to come from self/family and schools.

	CFA	The Village	Wellmore	Total		Yale
School	53%	31%	28%	36%		6%
Self	6%	23%	34%	22%		38%
Hospital/ED	3%	3%	2%	3%		0%
MCIS/211	3%	11%	10%	9%		7%
Police	1%	0%	1%	1%		12%
Community Provider/Provider within Agency	4%	13%	18%	12%		34%
Other	30%	18%	5%	17%		3%

Presenting Concern

CFA and Wellmore both reported suicidal ideation, behaviors, or self-injury as the most common presenting concern. Aggression and risk of harm to others were also somewhat common.

	CFA	Wellmore
Suicidal Ideation, Behaviors, or Self-Injury	57%	37%
Aggression/Risk of Harm to Others	20%	22%
Anxiety	6%	4%
Depression	3%	4%
High Risk Behaviors	5%	13%
Disruptive Behaviors	0%	9%
School Refusal	0%	6%
Other	20%	4%

Yale and The Village did not provide data specific to presenting concern. Based on the information The Village provided about diagnoses, Depression, Anxiety, and ADHD were common among youth visiting their UCCs. Yale reported the following top 5

diagnoses: Disruptive Mood Regulation Disorder, Suicidal Ideation, Major Depressive Disorder, Depression, and Adjustment Disorder.

Length of Stay

The majority of episodes for CFA and Wellmore were resolved within 3-5 hours, with many being less than 3 hours. Episodes longer than 5 hours were relatively rare for these agencies.

	CFA	Wellmore
< 3 hours	19%	37%
3-5 hours	66%	58%
>5 hours	15%	5%

The Village did not provide data on length of stay. Yale reported an average length of stay for discharged patients of 8.3 hours

Discharge

Over 90% of youth seen at UCCs (CFA and Wellmore) were able to be discharged back home at the end of the episode.

Released to:	CFA	Wellmore
Home	92%	96%
ED/Admitted (Yale)	8%	4%

The Village did not provide discharge data. Yale reported that they sent 60% of youth home and admitted 40%.

Sample of Policy Updates

• CT Health Horizons: Launched in October 2023, CT Health Horizons aims to bolster the nursing and social work pipeline while emphasizing workforce diversification. Managed by Connecticut State Colleges & Universities (CSCU), in collaboration with UConn and The Connecticut Conference of Independent Colleges (CCIC), the initiative focuses on expanding healthcare opportunities and enhancing workforce representation. Source: CT Health Horizons Strategic Plan

• Enhance Care Clinics Update: Effective October 14, 2023, private behavioral health clinics under the rehabilitative services benefit category must adhere to special access and quality standards. These clinics, known as Enhanced Care Clinics, have a separate fee schedule, offering higher fees than those not meeting the standards. Requirements include:

- Acceptance of 100% telephonic and walk-in referrals during business hours.
- Screening of referrals by trained intake workers or clinicians, followed by triage based on urgency.
- Timely evaluations for emergent, urgent, and routine cases
- Extended operating hours beyond routine business hours.
- Providers meeting quality and access standards receive enhanced rates for all routine outpatient services. Source: Enhance Care Clinics Update Notice

• Behavioral Health Services by Freestanding Clinics: Effective May 12, 2023, mental health services provided by freestanding clinics are categorized under the rehabilitation federal services benefit category. This change aligns with the reporting practices for substance use disorder services. Key points include:

- Flexibility in practitioner location and telehealth services remains consistent.
- No impact on reimbursement rates, covered services, or licensing requirements.
- Specifically applies to mental health services by freestanding clinics. Source: Behavioral Health Services Bulletin

- Urgent Crisis Centers: Effective April 1, 2024, DSS will enroll and pay certified providers to deliver children's mental health urgent crisis services. To be eligible, a clinic must hold a specific license from the Department of Children and Families (DCF) as an Outpatient Psychiatric Clinic for Children. Additionally, the clinic needs DCF certification to deliver these specific crisis services. The bulletin describes service billing codes used for the UCCs. Source: Provider Bulletin re: Implementation of Children's Mental Health Urgent Crisis Centers Services for Children 18 years Old and Younger

Sample of 2024 Legislative Bills Addressing Report Challenges

For informational purposes only, the addendum includes a sample of relevant legislation currently under consideration by other committees during the 2024 legislative session that addresses some of the challenges identified in this report. These are not legislative recommendations from the TCB.

- H.B. No. 5374 AN ACT CONCERNING ANNUAL INFLATIONARY RATE ADJUSTMENTS FOR NONPROFIT HUMAN SERVICES PROVIDERS. This bill would require DSS to annually increase Medicaid rates for "nonprofit human services providers" by the increase in the consumer price index for all urban consumers in the northeast region. Action taken Favorable Change of Reference, Senate to Committee on Appropriations.
  https://www.cga.ct.gov/2024/TOB/H/PDF/2024HB-05374-R01-HB.PDF

- H.B. No. 5459 AN ACT INCREASING RATES OF MEDICAID REIMBURSEMENT FOR CERTAIN PROVIDERS. This bill would increase rates of Medicaid reimbursement for certain providers. Action taken Favorable Change of Reference, Senate to Committee on Appropriations Committee
  https://www.cga.ct.gov/2024/TOB/H/PDF/2024HB-05459-R01-HB.PDF

- H.B. No. 5454 AN ACT CONCERNING MENTAL HEALTH SERVICES FOR YOUNG CHILDREN AND THEIR CAREGIVERS. The Commissioner of Social Services, in consultation with the Commissioners of Early Childhood, Children and Families and Mental Health and Addiction Services, shall create a strategic plan to maximize federal and state resources for mental health services for children six years old and younger, their caregivers and pregnant persons. Action taken Favorable Change of Reference, Senate to Committee on Appropriations.
  https://www.cga.ct.gov/2024/TOB/H/PDF/2024HB-05454-R01-HB.PDF

- S.B. No. 152 AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE OFFICE OF EARLY CHILDHOOD. To exclude those child care services providers that provide services to only school-age children from the requirement that they post a copy of the developmental milestones document; to include children under subsidized guardianship as part of the protective services category for the Care 4 Kids program; to replace state Care 4 Kids regulations with federal regulations and policies and procedures developed by the Commissioner of Early Childhood based on such federal regulations; and to require child care services providers to allow birth-to-three providers to deliver on-site services to certain children. Action Taken (LCO) File Number 94
- https://www.cga.ct.gov/2024/FC/PDF/2024SB-00152-R000094-FC.PDF

List of Resources provided by the DSS Autism Waiver Division

Asperger/Autism Network (AANE) Offers a variety of adult support groups and community connections program. Located at 51 Water Street, Suite 206, Watertown, MA 02472. The contact number is 617-393-3824. For more information visit https://www.aane.org/resources/adults/support-groups/ . Financial assistance is available by emailing groups@aane.org

Asperger/Autism Network (AANE) AANE offers a Life Management Assistance program (LifeMap) which is an intensive and individualized life coaching program for individuals with Asperger profiles. Services are offered to parts of Connecticut and can be accessed in person or online. There are a variety of LifeMap programs which include transition planning out of high school, life skills coaching or job finding assistance. Located at 51 Water Street, Suite 206, Watertown, MA 02472. The contact number is 617-393-3824. To learn more visit https://www.aane.org/resources/adults/lifemap-coaching/

Connecticut Family Support Network (CTFSN)- Provides information, resources, workshops, and trainings for families raising a child with ASD. You can also become part of their emailing distribution list which would likely disperse information about trainings, presentations, or events in the area. Allows for family-to-family contacts (or family networking opportunities). This might offer an opportunity for someone on the spectrum to network with other (peer-to-peer interactions). Please contact commsdirector@ctfsn.org to be connected with resources or call 860-744-4074.

Autism Families of Connecticut- Agency hosts young adults hangout activities for individuals ages 3-35. Gives individuals opportunities to build friendships, increase self-advocacy, and learn independence skills through activities such as cooking, creative arts, and leisure activities. Held once a month on a Friday. Cost vary, but can be around $15. Visit the website for upcoming dates and more information at Home - Autism Families Connecticut (autismfamiliesct.org) or call 860-474-3444 . They are located at 600 North Mountain Road, Newington, CT 06111

Autism Services and Resource Connecticut (ASRC)- Offers a variety of social and recreational activities throughout the year, in person and virtually. Individuals have an opportunity to meet virtually and the organization hosts outings in various parts of the state to allow individuals from the different regions to participate. Must register with Sara Taussik first. In-Person events may take place at different regions throughout the state to give individuals from different regions opportunities to participate. Located at 41 Marne Street, Hamden, CT 06514. You can call 203-265-7717 or visit ASRC – ASRC at Clifford Beers Community Health Partners (ct-asrc.org)

UCLA PEERS Clinic- Website offers social skills role play videos for young adults to learn basic rules of social etiquette. There are over 100 videos that are accessible for FREE. Visit https://www.semel.ucla.edu/peers/resources

A Little Compassion: The Nest Coffee House- Offers an array of activities for teens and young adults as well as family events. Gatherings are open to all with an emphasis on welcoming young adults with disabilities who have been searching for a place to make new friends, hangout and have fun. Activities include but are not limited to: game nights, painting and drawing, trivia nights, book clubs, acoustic nights, anime/manga nights, and much more. All Nest

Gatherings are FREE. Located at 162 Main Street, Deep River, CT 06417. The contact number is 860-322-3090. You can also visit https://thenestcoffeehouse.org/

Best Buddies CT BESTBUDDIES® - helps individuals build one-to-one friendships between people with and without intellectual and developmental disabilities (IDD), through school and community friendship programs that provide socialization opportunities to help erase the invisible line that often separates students or adults with and without IDD. Friendship programs include Best Buddies Middle Schools, High Schools, Colleges, Citizens, and e-Buddies. 175 Capital Blvd, Suite 402, Rocky Hill, CT 06067. Contact 203-234-3996 or visit https://www.bestbuddies.org/

Beyond My Battle- Online support group and educational resources for those individuals with serious illness, rare disease, and disabilities. Support is also available for caregivers. 112 W Circular St, Saratoga Springs, NY 12866. Contact (518) 328-4939 or visit www.beyondmybattle.org Held virtually.

GRASP- The Global and Regional Asperger Syndrome Partnership was created to improve the lives of adults and teens on the autism spectrum through community outreach, online support, education, and advocacy. Membership is free. 369 Lexington Avenue, 2nd FL, New York, NY 10017. Contact 1-888-474- 7277 or visit https://grasp.org/

Wrong Planet - is a web community designed for autistic individuals (and parents / professionals of those) with Autism, Asperger's Syndrome, ADHD, PDDs, and other neurological differences. We provide a discussion forum, where members communicate with each other, an article section, with exclusive articles and how-to guides, a blogging feature, and more. For more information, visit https://wrongplanet.net/