Behavioral Health Partnership Oversight Council

Child/Adolescent Quality, Access & Policy Committee

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www.cga.ct.gov/ph/BHPOC

Co-Chairs: Hal Gibber, Sherry Perlstein & Jeff Vanderploeg

Meeting Summary
Wednesday, January 21, 2015
2:00 – 4:00 p.m.
Value Options
Rocky Hill, CT

Next Meeting: Wednesday, February 18, 2015 @ 2 PM at VO, Rocky Hill

Attendees: Sherry Perlstein (Co-Chair), Jeff Vanderploeg (Co-Chair), Karen Andersson (DCF), Dr. Kathleen Balestracci, Lois Berkowitz (DCF), Brunilda Ferraj, Frank Fortunati, Elizabeth Garrigan, Marcy Kane, Susan Kelley, Beth Klink, Dr. Jason Lang, Dan Lyga, Allyson Nadeau, Joan Narad, Kim Nelson, Heather Paluso, Ann Phelan, Donyale Pina, Dr. Robert Plant (VO), Maureen Reault, Lynne Ringer (VO), Knute Rotto, Kathy Schiessl, Paul Shanley, Sherrie Sharp, Kristina Stevens (DCF), and Mike Williams

Update and Discussion of implementation of the Children's Behavioral Health Plan, focusing on Plan items not included in the Governor's Emergency Service Action Plan - Kristina Stevens, Administrator for the DCF Clinical and Community Consultation and Support Team

- Implementation Advisory Team. Finalized the Implementation Advisory Team with an emphasis on family participation. Members just finalized; will draw from Behavioral Health Plan Advisory Committee members with slots opened up for more parent participation. Invitation letters to go out soon, first meeting expected in February. Will use the www.plan4children.org website to post membership.
- SAFE Home Conversion. SAFE Homes will be converted to Short Term Family Intensive Treatment (S-FIT) programs: S-FIT is a short term (14-day) intensive program designed to preserve family based placement. This conversion is expected to be effective in March 2015. By August 2015, Emergency Mobile Psychiatric Services (EMPS) will play a gatekeeping role in access to SFIT beds. A workgroup will be convened sometime in February to discuss how EMPS will implement this role.
- Emergency Mobile Psychiatric Services (EMPS) expansion. DCF expects to expand the number of EMPS providers during State Fiscal Year 2015-2016.

- Care Management Entity (CME). As outlined in the Behavioral Health Plan, DCF is exploring the establishment of a CME structure. DCF is currently in the procurement process, so updates could not be provided to this membership.
- Expanding mental health coverage by private insurers. DCF working with Anne Melissa Dowling at the CT Insurance Department (CID), building off the progress made during the BH Plan, to examine what is covered, how much, under what circumstances.
- Promotion of Evidence-Based Practices. DCF continues further implementation of evidence-based practice (EBP) and best practice models including Child and Family Traumatic Stress Intervention (CFTSI) and the Modular Approach to Therapy with Children and Adolescents (MATCH) model. CFTSI and MATCH are being disseminated using Learning Collaborative methodology, which also address workforce development needs.
- Suicide prevention. CT Suicide Prevention Plan will be released next month.
- Enhancing access to information and resources for families. Enhanced the multidisciplinary evaluation completed for children and youth entering DCF care to include trauma screening. Through Public Act 14-115 legislation, DCF is collaborating with the Office of the Healthcare Advocate (OHA) on the mental health clearinghouse to ensure that families can connect with DCF Voluntary Services. DCF also working with Dept. of Developmental Services (DDS) and other state agencies that have information and referral systems to ensure linkages to DCF resources and services.
- Multidisciplinary Evaluation (MDE). MDEs had been previously used only for first time commitments to DCF; however, DCF has now approved use of the MDE for youth with a prior episode in DCF care.
- Screening. DCF Policy changes to promote early screening. DCF working with new "Project Launch Elm City" (federal grant) to advance health and mental health integration for youth up to 8 years old. Elm City Project Launch grant will initially focus on the Dwight neighborhood for children 0-8. Multiple partners involved in this effort including but not limited to: Clifford Beers; Mom's Partnership; Yale; Dept. of Public Health; and Wheeler Clinic.
- Home visiting for young children. The Office of Early Childhood (OEC) issued a home visiting report recommending specific investments and actions to create a coordinated home visiting system that effectively serves families and children. OEC plan was submitted Dec. 1, 2014 and DCF worked with OEC to align their plan with their BH Plan. OEC likely to come in with budget options to support early childhood elements of both plans.
- Infant Mental Health Training. DCF working to assure Infant Mental Health Training is delivered in all DCF regions - cross training to include DCF and private providers. Regions 2 and 3 are scheduled for this year. Being integrated in all DCF regions, using national and CT experts as consultants.
- Data. DCF will activate the waitlist functionality in the Programs and Services Data Collection and Reporting System (PSDCRS) to better assess capacity and utilization and also renaming PSDCRS to the Provider Information Exchange (PIE).

- School Based Mental Health. Workgroup on school based health centers underway; facilitated by Dept. of Public Health (DPH) with DCF's participation to examine capacity of school based health centers for meeting students' mental health needs.
- Access to psychiatric consultation. ACCESS Mental Health went live in June 2014. As of 12.31.14 a total of 310 practices with 1,247 practitioners have enrolled in the program. Implementation of Access Mental Health has been going very well; 320 practices and 1,247 individual practitioners have signed on to participate and 617 youth have received services to date.

Updates and Discussion on Implementation and Sustainability of Evidence-Based Practices

A. Trauma-Focused CBT- Dr. Jason Lang, CHDI
B. Modular Approach to Therapy for Children- Anxiety, Depression, Trauma, & Conduct (MATCH-ADTC) – Dr. Jason Lang, CHDI
C. Multisystemic Therapy (MST) – Mike Williams, Advanced Behavioral Health

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- Summaries of Trauma Focused Cognitive Behavioral Therapy (TF-CBT), Modular Approach to Therapy with Children and Adolescents with Anxiety, Depression, Trauma, and Conduct Problems (MATCH-ADTC), and Multisystemic Therapy (MST) were briefly described with respect to number of teams, number of children and families served, and outcomes.
- Strengths and benefits of evidence-based practices (EBPs) were noted and the distinctions between clinic-based and home-based EBPs were discussed.
- Despite number and quality of EBPs in Connecticut, most children who receive mental health treatment are still more likely to receive treatment that is not evidence-based and supported by rigorous supports (such as regular data collection to monitor treatment response/outcomes)
- A number of implementation barriers were identified, including:
    - Time required to train and sustain EBPs
    - Reimbursement: EBPs do not "fit" well with current rate structure; insufficient reimbursement to cover full cost of implementation (e.g., case management, collateral contacts, data collection, Quality Assurance/Improvement data collection, consult calls)
    - Clinician turnover and workforce development issues
    - Challenges of multiple (and sometimes, overlapping or "competing") EBPs
    - Higher than desired no-show rates and lower than desired "successful completion" rates

        - Particularly for clinic-based EBPs (these rates tend to be better for home-based EBPs since they inherently address a number of access barriers).

    - Ensuring referrals go to the most appropriate EBP model
    - Many EBTs require additional time for supervision, team meetings, and ongoing training. This reduces the time clinicians are available to see patients thereby adding to the challenge of meeting access requirements for outpatient EBTs and resulting in long waiting lists for most in-home EBTs

- A number of policy recommendations and strategies were identified:
    - Consider disseminating a "common elements" approach as a complement to CT's range of clinic-based EBPs
        - There is a need to enhance the quality of clinical care in outpatient settings since most youth still do not receive an EBP in clinic settings. This approach would include implementation supports such as ongoing training in effective treatment strategies and use of a data feedback system to monitor outcomes and engage in ongoing Quality Improvement.
    - Examine reimbursement rates for EBPs to match actual cost of delivering EBPs
        - Ensure reimbursement practices align with Affordable Care Act reimbursement models that will emphasize outcomes-based reimbursement.
        - Phase in any proposed changes over time to minimize risk to providers and disruption to the mental health system that would come with a "one-shot overhaul" of the payment system
        - Consider engaging in a rate-setting process and methodology similar to what was done with the Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS)
        - Sustain grant funding for EBPs
        - Consider enhancing Medicaid reimbursement rates for EBPs to incentivize use and cover implementation costs
        - Work with commercial insurance providers to reimburse adequate rates for EBPs
        - Consider social entrepreneurship models (e.g., Social Impact Bond) to fund delivery of EBPs

New Business

- None

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