Behavioral Health Partnership Oversight Council

Child/Adolescent Quality, Access & Policy Committee

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Co-Chairs: Steve Girelli & Jeff Vanderploeg

Meeting Summary
Wednesday, November 15, 2017
2:00 – 4:00 p.m.
Beacon Health Options
Rocky Hill, CT

Next Meeting: December 20, 2017 @ 2:00 PM at Beacon Health Options, Rocky Hill

Attendees: *Dr. Jeff Vanderploeg (Co-Chair), Dr. Lois Berkowitz (DCF), Chris Bory (Beacon), Eliot Brenner, Annie Calamari, Amy Cholawa, Yohanna Cifuentes, Sean Cronin, Amy DiMauro, Beth Garrigan (Beacon), Susan Graham, Mary Held, Dr. Irvin Jennings, Susan Kelley, Debbie McCusker, Joan Narad (Beacon), Ann Phelan (Beacon), Donyale Pina (DCF), Heidi Pugliese (Beacon), Maureen Reault (DSS), Kathy Schiessl, Gregory Simpson (Beacon), and Dr. Stephney Springer (DCF)*

Introductions:

Co-Chair Jeff Vanderploeg convened the meeting at 2:04 PM and introductions were made. He reminded participants to sign in.

Follow-up to meeting of October 18, 2017

None

The Future of Evidence-Based Practices in Connecticut (EBPs) – Dr. Jason Lang, Ph.D. Child Health and Development Institute (CHDI) and Dr. Eliot Brenner, Ph.D. Child Guidance Center of Southern Connecticut (CGCSC)

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P Presentation (Lang

Jason Lang (CHDI) and Eliot Brenner (Child Guidance Center of Southern Connecticut) gave the presentation (see the above icon).

1. Presentation by Dr. Jason Lang, CHDI
   - Reviewed the range of EBPs available in Connecticut, with a focus for this presentation on data from Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Modular Approach to Therapy for Children (MATCH), and Cognitive Behavioral Intervention for Trauma in Schools (CBITS)

- Outcomes from each of those three EBPS indicate significant improvements in functioning
- The rates of improvement in TFCBT and MATCH were higher than the rates of improvement for other outpatient treatment models, including "other EBPs" and "non-EBP treatments."
- Rates of treatment completion appear to be higher for EBPs, and in some cases much higher than usual care; for example, treatment completion rates for CBITS are about 90%.
- A member asked which treatments are included in "other EBPs" category.
    - Presenter responded that treatments like Cognitive Behavioral Therapy (CBT), Dialectical Behavior Therapy (DBT), Brief Strategic Family Therapy (BSFT), Motivational Interviewing (MI), and others. These are identified by the clinicians, and the "other EBPs" category typically do not include the implementation supports (clinical consultation calls, quality assurance, regular data feedback reports) that are part of TFCBT and MATCH.
- A member asked whether kids receiving outpatient are on medications, and whether this could influence the finding that youth getting EBPs improve more.
    - Presenter indicated that there are a number of potential factors that could impact the finding that outcomes are better for EBPs than other treatments, including: medication, treatment dosage, length of stay in care, treatment matching, and other factors.
- A member asked whether outcomes could be identified separately by race, ethnicity, age, gender, and other factors
    - The presenter indicated that this can be done. For outpatient treatment in general (including EBPs and non-EBPs) there appear to be some disparities in the rates of improvement for youth of color, and for some age groups
    - These analyses are being conducted for TFCBT, MATCH, and CBITS and the findings from those analyses will be available in the near future.

2. <u>Presentation by Dr. Elliot Brenner, CGC Southern CT</u>

- Only about 8.5% of all youth receiving treatment receive an EBP, only about 1/3 of those who receive treatment receive at least "minimally adequate treatment."
- EBPs are effective and should be supported, but can be more effective and accessible with changes to reimbursement structures (e.g., value-based purchasing) and delivery methods (e.g., integrated care, use of technology)
- EBPs are often expensive for providers to implement under a fee for service reimbursement structures, which limits broader dissemination
- Access to care can be defined as physical accessibility (delivered in convenient settings and at convenient times for families), affordability (affordable for low-income families, and affordable for providers to implement), and acceptability (the populations most in need value them and utilize the services at appropriately high rates)
- Using Child Guidance Center of Southern CT as an example, the estimated cost for getting TFCBT to all children in their clinic would be very high
    - Dr. Brenner acknowledged the actual cost required would be very difficult to calculate

    - The increase in grant funding required to scale up EBPs is likely out of reach; therefore, CT should consider alternative reimbursement structures to increase access to EBPs
- There is a great need for bilingual clinicians and not nearly enough bilingual clinicians available
    - A member shared a story of clients that are unaccompanied, uninsured minors that are struggling with trauma symptoms, but may not even seek out the treatment system at all, highlighting the need for increased outreach to this population.
    - Presenter indicated that undocumented clients may not seek out treatment for fear of being identified as undocumented and deported.
- A member asked about the role of engagement, particularly with clients from racial and ethnic minority families, and how clients of color may respond better to all treatment, including EBPs, with an enhanced focus on engagement.
- A member asked whether outcome data exist to look at follow-up outcomes months or years after treatment ends, including whether they use fewer services than youth receiving non-EBPs.
    - A presenter indicated that the national literature on long-term follow-up for youth receiving EBPs indicates that EBPs save money in the long-term
- A member asked whether EBPs are available regardless of insurance type.
    - Presenters indicated that it is easier for youth in Medicaid to receive EBPs; the cost to providers of training in and delivering an EBP is high, which limits access; private practitioners may not accept Medicaid or any other insurance, and it's unknown how many of them deliver EBPs.
- A member indicated that IICAPS is nearly an EBP and has some data for effectiveness, and was spread through a Medicaid Waiver which should be considered for increasing access.
    - Other members indicated that IICAPS has not reached EBP status, and wondered whether/when the results of an IICAPS randomized study would be ready for review
- A member noted that outpatient clinics lose money every year and new reimbursement models are needed to keep them afloat.
- One member indicated that the supply of clinicians, and those looking to enter the provider system, is not sufficient to meet the need
- The presenter identified possible solutions to deliver EBPs to more people in need and to address issues related to access to treatment and EBPs
    - **Shift to value based purchasing** and population-based reimbursement models
    - **Task shifting**
        - Allow some services to be provided by non-clinical staff, which can be effective and costs less, freeing up services delivered by more highly trained workforce
        - Task shifting is also supported to a great degree by the reimbursement structure, such as value-based payment and other regulations
    - **Promote integrated (physical and mental health) care** (e.g., FQHCs). Put behavioral health clinician in pediatric primary care and other settings, have those providers provide short-term treatment to those who need it, and refer those who need longer-term treatment to other care settings.

        - One member indicated that integrated care can be challenging if families do not see the same physician at each visit, over time.
    - **Focus on stigma reduction**, increase acceptability of care, provide earlier intervention
    - One member noted the importance of considering alternative therapies to address gaps in the treatment array (e.g., sports therapy, art therapy, drama therapy, equine therapy). In some states, these services are reimbursed by payers. Sometimes these alternative treatment providers are referred to as "coaches" to increase acceptability and reduce stigma
        - One member noted that many family members ask for alternative therapies, but our reimbursement structures do not support them.
    - **Consider use of technology** to deliver treatments (online, virtual reality, apps, text messaging, social robots, real-time assessment and intervention)
        - A member suggested including Access Mental Health in future presentations on the potential role of integrated physical and mental health care
- One member asked about the potential to use virtual learning to train in EBPs, to help alleviate the financial burden for providers to train clinicians in an EBP, particularly travel
    - Presenters noted that clinical consultation calls delivered in EBPs are done by phone
- **Incentivize graduate programs to fully train in EBPs,** shifting the burden there rather than the provider community (i.e., enter the workforce with EBP training)
- A member asked how health equity was going to be integrated through all BHPOC activities
    - Members indicated that CAQAP is doing more in this area than any other committee
    - CAQAP is asking all presenters to include focus on disparities to the extent possible
    - The Executive Committee continues to discuss how to operationalize a health equity focus in their work

Update from Consumer and Family Advisory Council- Mary Held, Deb McCusker and Susan Graham

- There are 10 emerging adults on the CFAC Emerging Adults Committee. They are being trained to conduct various trainings in schools and communities.
- CFAC is looking to move the iCAN conference to a larger venue due to recent attendance growth
- Three community meetings were recently conducted by CFAC (Waterbury, Meriden, Bridgeport), in Spanish, and by youth. A liaison will be identified at each community collaborative who can inform the work of the statewide CFAC meeting
- CFAC going to LOB in January to tour the Capitol and learn about the legislative process
- CLAS standards committee will be collaborating with the CONNECT CLAS workgroup.

- Steve Girelli presented to CFAC members on the BHP OC structure, goals, and purpose and the ways families and consumers can get more involved. The presentation was very well-received.

New Business and Announcements:

Co-Chair Jeff Vanderploeg asked for any questions, comments, new business, or announcements. Susan Kelley expressed her concern that the issue of Health Equity has not been consistently followed but agreed that this committee has done more than any other in its commitment to have presentations centered on Health Equity. The BHPOC Executive Committee will be addressing this concern in early December. Hearing nothing else, Jeff announced the next meeting for Wednesday, December 20, 2017 at 2:00 PM at Beacon Health Options in the Hartford Conference Room on the third floor and then adjourned the meeting approximately at 3:35 PM.

Next Meeting: Wednesday, December 20, 2017 @ 2:00 PM, 3rd Floor, Hartford Conference Room, Beacon Health Options in Rocky Hill, CT