Behavioral Health Partnership Oversight Council

Child/Adolescent Quality, Access & Policy Committee
Legislative Office Building Room 3000, Hartford, CT 06106
(860) 240-0346 Info Line (860) 240-8329 FAX (860) 240-5306
www.cga.ct.gov/ph/BHPOC

Co-Chairs: Steve Girelli & Jeff Vanderploeg
Meeting Summary
Wednesday, November 18, 2020
2:00 – 4:00 p.m.

Next Committee Meeting Date: Wednesday, December 16, 2020 at 2:00 PM via Zoom

Attendees: *Dr. Steve Girelli (Co-Chair), Dr. Jeff Vanderploeg (Co-Chair), Dr. David Aversa (Beacon), Dr. Lois Berkowitz (DCF), Maria Brereton, Yohanna Cifuentes (Clifford Beers), Kim Davis (OHA), Melissa Deasy, Tara Ferrante, Tammy Freeberg, Stacey Forrest, Bet Gailor, Elizabeth Garrigan (Beacon), Colleen Harrington (DMHAS), Irv Jennings, Beth Klink, Jason Lang (CHDI), Tanja Larsen, Valerie Lilley (OCA), Keri Lloyd (DSS), Jack Lu (CHDI), Tim Marshall (DCF), Maureen O'Neil Davis, Kelly Phenix, Donyale Pina (DCF), Vincent Russo (DCF), Kathy Schiessl, Erika Sharillo (Beacon), Howard Sovronsky, Dr. Stephney Springer (DCF), and Janessa Stawitz (Jud)*

Introductions

Co-Chair Jeff Vanderploeg called the meeting to order at 2:05 p.m. and reminded participants that the meeting was being recorded. He had participants introduce themselves through the chat box with their names and organizations they represented.

Comments and Discussion from the October 2020 Meeting

The focus of the meeting had been the launch of a new ad hoc workgroup on racial justice and health equity. There were no comments.

Outpatient Clinics: Strengths, Gaps, Issues, and Opportunities-

Yohanna Cifuentes, PhD, LCSW, Director of Outpatient Services, Clifford Beers Clinic: Yohanna provided background information about Clifford Beers and the client population it serves. The agency serves the greater New Haven community. Clients represent varying socio-economic statuses (SES), races/ethnicities, and languages. In 2019 the clinic saw 991 clients with the following racial/ethnic breakdown: Hispanic 41%; Black 28%; White 26%; Multi-Racial 2%; Other 2%; and Unable to Report 1%.

Service delivery has been greatly impacted by the pandemic. For clients with

transportation issues, attendance was enhanced by technology. However, the change to a virtual provision of services has been a challenge for many low SES clients due to limited access to technology. Some are connecting by phone-only because they don't have computers and some don't have enough capacity on their phones to download applications. Among those who do have computers, downloading virtual platforms is sometimes challenging. Providing technological help to Spanish-speaking clients has been made more difficult by the language barrier.

Another challenge has been the variability in schools openings and closings. Children who are participating virtually in school may have additional challenges accessing virtual clinical services due to competing demands between school and services on computer equipment and internet bandwidth. The high demand for bilingual services has taxed the resources of bilingual clinicians. From a financial perspective, much of what the clinic does to overcome the barriers created by the pandemic has been non-billable.

The pandemic also impacted referrals to the clinic. A comparison of intakes from March to December of 2019 versus the same period in 2020 (see PowerPoint) revealed a dramatic decrease in intakes, especially for persons of color.

The clinic conducted a survey of its clients in July of this year regarding the pandemic's impact on treatment. Preference among the nearly 130 respondents was 47% for in-person versus 35% for telehealth with 18% having no preference. Spanish-speaking clients were overrepresented among those who preferred in-person services, and more Spanish-speaking clients reported challenges with telehealth than did English-speaking clients. When asked about the types of challenges created by telehealth, over half of the respondents cited technology and one-quarter cited privacy concerns. Technology was a bigger issue for Spanish-speaking clients than English-speaking clients, while the reverse was true for privacy.

Among the changes made by the clinic were an increase in translation and interpretation availability, additional case management, and greater utilization of advocates. The clinic has focused on balancing responsiveness to client preferences for in-person services against the goal of maintaining health and safety. They are handling this tension between client preference and safety by being as direct and transparent as possible.

Tanja Larsen, LCSW, Vice President of Clinical Operations, Community Child Guidance Clinic (CCNG): Tanja opened with discussion regarding Bronfenbrenner's ecological systems theory model, which posits four concentric spheres of influence on a child's development; microsystem, mesosystem, exosystem, and macrosystem. Health equity in the behavioral healthcare system can be examined from the micro level (between clinician and client/parent) then outward to clients/school or client/receptionist; and then engagement with other systems in their life. We must look at health equity through the lens of how we can make changes in our system. We must examine the systems through a health equity lens.

We as providers need to look at how engagement starts at the very beginning. From a

microsystem view, interaction starts with the phone call to initiate services. For example, is there a live phone answer versus phone tree? Who do clients talk to first and how are they treated by that person? Can they access the services they want/need easily and with few obstacles?

OPCs are consistently foundational in providing care and really held their ground when the pandemic hit. In looking at pre- to post- COVID care, CCNG had similar observations to Clifford Beers. They saw a 22% drop in clients accessing the clinic with the change to telehealth. Thirty percent of that drop was accounted for by Black and Hispanic clients. When the clinic reopened, it looked at who could be re-engaged and found about a 10% jump in persons of color. As regards client age, 9-11-year-olds were among the age group that had the highest drop-off/resumption rate.

As a system, we need to create learning opportunities for the staff, from receptionist all the way up to CEO, to better equip them to serve during this period. Also, clinicians need space to heal their own selves. The clinic looked at clinician caseloads, as is done with DCF personnel and with evidence-based practices, though not with OPCs. They are trying to look at carefully managing caseloads to encourage and provide for clinicians' self-care and attention to their own implicit bias and intergenerational trauma.

Tanja indicated that the question of access during COVID has been critical. There has been a difficult process of finding balance between staff needs and client service provision. They have tried to be sensitive to fears that come up with clinicians and others in the workforce.

It is also critical to look at the larger systems of care. There is a big jump from higher levels of ambulatory care (e.g., IICAPS) to regular OPC, and this can be extremely tough for the clients and for the staff, especially at the lower levels of care. One thing that helps is to bring directors together across these levels to talk about challenging cases and to strategize for smooth transitions across levels of care for these clients. For example, if a client is moving from a higher level to OPC, could we be providing two sessions per week during the transition period? This requires time for planning and anticipation of needs during transition. COVID has highlighted the value of flexibility in transitioning clients across levels and types of care. We need flexibility to individualize services (e.g., virtual session or in-home session for OPC clients). These can make a huge difference, including in reducing the need for higher levels of care. Transportation is a huge potential problem. CCNG has been using its own in-house transportation "department." This has not been reimbursed but can make a huge difference for clients and might be of value to other clinics.

A question was asked if telehealth increases access for persons of color. Tanja explained that perhaps it removes some of the obstacles, but client preference seems to be for in-person services.

Tanja closed with suggestions for enhancing client experience with telehealth, including providing telehealth-friendly therapy rooms, screen sharing helpful information, use of

the chat room, and other ways of engaging, such as mixing up the types of therapy, the length of sessions, and who participates in the sessions (e.g., just young child or young child with parents).

Kathy Schiessl, LCSW, Sr. Vice President of Child & Family, Community Health Resources (CHR): Kathy provided background regarding CHR. The agency has over 800 employees and last year served over 25,000 individuals through 32 programs in 15 locations and 19 schools with multiple outpatient locations. All clients have equal access to services. CHR uses an assessment center to triage calls to the appropriate level of care. They try to make the call system very user-friendly, especially that there be a live answer and immediate resolution to the call.

The organization has implemented a Hero Hotline for people in healthcare and education.

One challenge of the pandemic has been school-based work with changing school models and the impact this has on client access to therapy sessions. Also, education staff are overwhelmed and they have little bandwidth to identify kids who need services. Telehealth has improved access for those with childcare and transportation issues. Challenges to use of telehealth include its effectiveness with young children, internet access, computer fatigue, and computer equipment. CHR received private and foundation funding to provide clients with the equipment needed for telehealth.

About 13% of CHR's clients identify as Latino, so there has been a significant need for Spanish-speaking therapists. Four out of 5 of their clinicians are Spanish-speaking in order to meet this need. In order to achieve this level they have employed a variety of strategies, including holding positions for diverse candidates, use of internships, flexibility in scheduling, providing scholarships and internships for bachelors level employees to pursue education, and providing hiring incentives.

Having a strong continuum of care allows CHR to give people the services they need. Because they treat adults they can cross-refer within families between parents and kids. One of the challenges created by their size, large continuum, and geographic spread is that staff don't see each other, so collaboration is harder. A strategy that they have employed to address this challenge is triggers built into the electronic health record to alert multiple staff working with same family.

CHR has also found focusing on care integration (e.g., primary care services, pharmacy services, wellness, etc.) to be effective in providing for myriad needs of the children and families they serve.

Kathy stressed that health equity has to be an organizational priority from the CEO down. For example, they utilize one-to-one and group conversations between CEO and staff regarding their treatment of both employees of color and clients of color. CHR also examines data about the racial/ethnic make-up of their clients as compared to make-up of the communities and the make-up of their staff. Also, the organization does not assume that the language used in the first call is the preferred language and provides services in

the preferred language. Formal interpretation services are utilized when needed with ongoing evaluation of their effectiveness. They have integrated cultural and religious questions into their initial assessment, which has led to an improvement in engagement (as measured by return for subsequent session) from 67% to 81%. They also examine the customer friendliness of the phone system, as well as conduct walking activities from parking into service space to see from the clients' eyes what their experience is like.

CHR's clinic has a very low incidence of emergency department utilization and an inpatient hospitalization rate of only 2%, owing in part to the emphasis they place on safety and crisis planning, protective factors, identification of risk factors. They also utilize as needed their own internal higher levels of care and wrap services around the youth who are at risk. Kathy described Project Notify, a program with DSS that alerts providers when a client presents for either medical or psychiatric needs at an emergency department and within 24 hours following discharge. Outpatient is a holding ground for clients coming from the hospitals for a variety of reasons, including that face-to-face services are less available. Also, often higher level programs between inpatient and OPC are less available because of the pandemic, and more of burden falls on OPC.

Ensuing discussion among the group highlighted that "one-stop shopping" is the ideal and strongly preferred among clients. Also, the inadequacy of inpatient psychiatric beds places strong challenges on clinics and can contribute to trauma among OPC staff.

One participant noted that these transitions across levels of care are a big challenge for parents, especially when there are temporal gaps, leading to a suggestion that the United Way service array could be expanded to be more immediately responsive and helpful to these kids and families. A question was raised about whether mobile crisis could address this need and would more case management be helpful. An observation was offered that these programs seem more comfortable in bridging among lower levels of care than bridging between inpatient and community levels of care. That said, it was noted that transition services as kids leave inpatient are very helpful when available. Also, for higher end cases, weekly case meetings can be helpful across providers and programs/service types and levels. Finally, it was remarked that intermediate levels of care are inadequately available to manage step down from inpatient and residential.

BHPOC Ad Hoc Workgroup on Health Equity and Social Justice in Behavioral Health-

Co-Chair Steve Girelli reported that he provided the workgroup with a bulleted summary of the concerns and ideas generated in the last meeting of this committee. This list had also been sent to the CAQAP distribution. There was considerable interest in the workgroup about it, leading to discussions on such issues as the decision to make the workgroup permanent versus temporary, the breadth of the topics it should address, and the composition of the group with regard to consumer representation.

Update from Consumer and Family Advisory Council (CFAC)-Kelly Phenix

CFAC **m**et last week and had a comprehensive presentation on Husky with a high number of participants. They now have an interpreter so they can do zoom meetings with simultaneous English and Spanish. Yvonne Jones from Beacon can provide similar help to other interested groups.

New Business and Adjournment

There being no new business or announcements raised, Co-Chair Jeff Vanderploeg adjourned the meeting with Thanksgiving wishes at 3:52 p.m. A reminder was provided that the next meeting will be Wednesday, December 16, 2020, 2:00 – 4:00 PM via ZOOM.

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