Behavioral Health Partnership Oversight Council

Child/Adolescent Quality, Access & Policy Committee

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Co-Chairs: Steve Girelli & Jeff Vanderploeg
Meeting Summary
Wednesday, April 20, 2022
2:00 – 4:00 p.m.

Next Committee Meeting Date: Wednesday, May 18, 2022 at 2:00 PM via Zoom

Attendees: *Dr. Steve Girelli (Co-Chair), Dr. Jeff Vanderploeg (Co-Chair), Dr. Lois Berkowitz (DCF), David Borzellino, Dr. Jeana Bracey (CHDI), Computer iPhone, Sandra Czunas (OSC), Jaya Daptarder, Kim Davis (OHA), Robin Entress, Tammy Freeberg, Marissa Glaude, Kerri Griffin, Jessica Guite, Brenetta Henry, Dr. Irv Jennings, Sean King ((OHA), Beth Klink, Dr. Jamie LoCurto (CHDI), Ellen Mathis, Maureen O'Neill-Davis, Kelly Phenix, William Savanelli, Kathy Schiessl, Erika Sharillo (Beacon), Amy Soto (DPH), Howard Sovronsky, Ari Steinberg, Melanie Wilde-Lane (SBHC), and Rod Winstead (DSS)*

Introductions

Dr. Steve Girelli opened the meeting at 2:06 PM and welcomed the participants. He notified participants that the meeting was being recorded and requested that all introduce themselves with name and organization using the chat function.

Comments and Discussion from the March 2022 Meeting

There were no comments or questions from the March 2022 meeting.

Overview of School Based Health Centers- Melanie Wilde-Lane, Executive Director of the CT Association for School Based Health Centers

Melanie Wilde-Lane provided an overview of school-based health centers (SBHCs) in Connecticut. Wilde-Lane noted that there are 93 SBHC sites operated in 28 communities. Sites are licensed by DPH, DCF, or both depending on their scope of services. Most SBHCs provide both physical and behavioral healthcare. Funding sources include DPH grants (state), the HRSA (federal) Maternal and Child Health Block Grant funds, Medicaid and commercial insurance billing, and funds from local Boards of Education. SBHCs provide services to 44,000 students annually, and over 100,000 visits are provided annually. With the exception of one site, SBHCs do not bill families for co-pays or deductibles. SBHCs serve all students regardless of insurance with no out-of-pocket costs to students or families. Generally, students are enrolled in SBHCs before receiving services.

Wilde-Lane underscored the many ways in which SBHCs reduce barriers to care such as transportation, insurance type, cost, and immigration status. She indicated that SBHC no-show

rates are generally very low, and students miss less school time for SBHC appointments when compared to appointments in the community. Additionally, she noted that recent increases in telehealth have further expanded access to care. Although SBHCs do not aim to replace community-based pediatric primary care, many students do utilize SBHCs for their primary care. SBHCs provide well-child visits, physical examinations, immunizations and vaccinations (including for COVID-19), and some acute care visits (e.g., colds, strep throat, headaches, allergies, conjunctivitis). School nurses triage acute health concerns before sending to SBHCs.

In the area of mental health, SBHCs provide psychosocial assessment; individual, group, and family intervention including evidence-based treatments; crisis intervention; consultation to school personnel; psychoeducational services; and referral and follow-up to services. She noted that SBHC staff spend a fair amount of time in the classroom as well, providing psychoeducation and classroom support. The population served tends to be predominantly youth of color, due in part to SBHCs being located primarily in urban centers. During the pandemic, enrollees and total visits have dropped but they are seeing increases now that are starting to approach pre-pandemic levels.

In 2019-20, there were approximately 50,000 mental health visits. During the pandemic, Wilde-Lane noted that SBHC staff have observed increases in depression, anxiety, and loneliness. Simultaneously, SBHCs had to pivot increasingly toward telehealth services to address these concerns. SBHCs found that parent contact information was outdated or inaccurate, connecting to care took more time, parents/caregivers were feeling overwhelmed, and students and families had more unpredictable schedules leading to more cancellations and no-shows. New funding of $7 million has passed Appropriations and is awaiting a signature from the Governor's Office. Those funds might be directed toward approximately 36 high-need SBHC sites, but final implementation details are pending.

Participants asked whether SBHCs had Enhanced Care (ECC) status, and Wilde-Lane indicated they did not. A participant asked about hiring APRNs and psychiatrists, and Wilde-Lane indicated that APRNs are generally the staff providing physical health primary care services. She indicated that some sites have child/adolescent psychiatrists that provide services, particularly for SBHCs that are operated by Federally Qualified Health Centers (FQHCs). A participant asked about service accessibility for students in educational out-placement. Wilde-Lane responded that SBHCs are responsible for following up with SBHC-enrolled students when they are in out-placement settings. Another participant commented on the need for improving communication and outreach pathways between SBHCs and parents/guardians, and Wilde-Lane agreed that this is needed.

Overview of Comprehensive School Mental Health Initiatives- Dr. Jeana Bracey (CHDI) and Dr. Jamie LoCurto (CHDI)

The presenters started by asking participants to offer their thoughts on what role districts can play in helping students and their families access behavioral health services. The group's ideas included improving awareness of needs, improving identification of needs, and facilitating referral and connection to care. Presenters then turned to providing an overview of Project AWARE, a federally funded school mental health initiative. Currently participating districts include Middletown, Naugatuck, and Windham. Presenters talked about the core elements of

AWARE's comprehensive school mental health approach including establishing family/community partnerships, supporting the school workforce, and providing all three tiers of intervention. They also discussed how the school mental health work has been embedded within statewide behavioral health planning and system development efforts. Key tasks of AWARE include creating buy-in, training and implementation, and sustainability/expansion.

The presenters discussed several key activities being offered to AWARE participants. Participants are being trained in the Question, Persuade, and Refer (QPR) approach for suicide assessment and intervention. Districts are also completing the SHAPE needs assessment system. Another area of focus is promoting screening in schools, and offering social-emotional learning (e.g., RULER). The AWARE initiative is also training staff to deliver the Cognitive Behavioral Intervention for Trauma in Schools (CBITS) for 6th to 12th grade students, as well as its companion model, BounceBack, for K – 5th grade students. Both are evidence-based group interventions to address trauma. Finally, AWARE ensures that participating schools have effective relationships with Mobile Crisis, SBHCs, and community-based providers to assist students with needs that exceed the capacity of schools (tiers 2 and 3).

Overall implementation was significantly impacted by the pandemic; however, districts are making rapid progress in implementing the model. The data indicated that staff are getting trained in QPR, and that all participating schools have achieved "gold status" on completing the SHAPE needs assessment system. In total, 171 students have been screened, among a "targeted" population (universal screening is not being implemented in AWARE schools). A total of 33 teams (1,091 staff) have been trained in RULER with 692 classrooms implementing the program. A total of 42 clinicians have been trained in CBITS and/or BounceBack, and 112 students have received the intervention. Finally, on-site clinicians have been identified in each school to address crisis situations and each district also has an updated MOA with their local Mobile Crisis provider. A significant proportion of students are referred for services when indicated. Recommended actions included focusing on quality, developing school-based data dashboards, improving continuity of care, addressing workforce challenges, and addressing policy challenges that stand in the way of providing school-based mental health care.

A participant asked whether there has been an effort to incorporate into school mental health efforts the funding available regarding impact of social media, or the rollout of 9-8-8. The presenters responded that they are planning for communication to schools about the rollout of 9-8-8 and although they had not done so to date, they would consider integration of other grants such as those related to social media impact.

There may be some funding coming out from SAMSHA coming out for funding related to this 988 National Suicide Prevention Lifeline - https://www.samhsa.gov/find-help/988 ….
https://www.samhsa.gov/sites/default/files/988-appropriations-report.pdf

SM-22-013
Center of Excellence on Social Media and Mental Wellness
Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
https://www.grants.gov/web/grants/view-opportunity.html?oppId=338875

Consumer Family Advisory Council (CFAC) Update

Ellender Mathis provided the update from CFAC. She indicated that there was a focus group led by Amy Soto from DPH to talk about family experiences with behavioral health care. CFAC is also developing a handbook for their participants. CFAC's iCAN conference is being planned for mid-September, likely either 9/15 or 9/22.

Other Business, Announcements, and Adjournment- Steve Girelli & Jeff Vanderploeg

A participant asked if there was any state planning to address the needs of Ukrainian refugees who are in need of services. A DCF representative responded that IRIS in New Haven, as well as other refugee agencies, are likely to have more information about the need and services being offered. The meeting was adjourned at 3:58 p.m.

Purpose Statement: *This committee brings together family members, advocates, providers, state agencies, and other partners to maximize the combined impact of services and supports funded by Medicaid and managed by the Behavioral Health Partnership (BHP), and other grant funded services within the children's behavioral health service system. The CAQAP identifies and addresses key issues of concern to consumers and providers with a focus on enhancing quality and access to services. The committee reviews data that measure the effectiveness of the initiatives, policies, and services of the behavioral health system under the BHP and addresses the needs, strengths, and gaps in the behavioral health service system. The committee reports to the Council on findings and issues and makes recommendations within the purview of the Council's authority. The CAQAP, in collaboration with the Adult QAP Committee, also works through the Council to provide input to the State's plan for federal health care reform and other emerging mental health policy and program developments.*

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