Behavioral Health Partnership
Oversight Council
Coordination of Care Committee
Council on Medical Assistance Oversight
Quality & Access

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The Committee will work with the Departments of Social Services, Children and Families, and Mental Health and Addiction Services, and the administrative services organizations that administer medical, behavioral health, dental and non-emergency transportation, to identify and monitor key issues that may impact whether individuals and families in the HUSKY Health program and receive person-centered coordinated services. The Committee and its partners, along with parent and community input, will seek to ensure that participants in the HUSKY Health program and receive behavioral health care that is coordinated with their medical (primary and specialty care), dental, pharmacy, and transportation services.

Co-Chairs: Rep. Jonathan Steinberg, Janine Sullivan-Wiley, Sabra Mayo and Kelly Phenix
MAPOC & BHPOC Staff: David Kaplan

Wednesday, July 27, 2022
1:00 PM – 3:00 PM
Via Zoom

Present on call:

Staff: David Kaplan (BHP-OC)
Co-Chairs: Janine Sullivan-Wiley, Kelly Phenix, Sabra Mayo, Rep. Jonathan Steinberg
Other participants:
Lois Berkowitz (DCF), Carlos Blanco (Beacon, translation services), Thomas Burr (NAMI), Neva Caldwell (CFAC), Teresa Carmen, Roberta Cook, Sandra Czunas, Maureen O'Neill Davis, Howard Drescher, Kathy Flaherty (CLRP), Carmen Gonzalez (CHNCT-HUSKY Health), Bill Halsey (DSS), Brenetta Henry, Rep. Susan Johnson, Yvonne Jones (Beacon), Sean King (OHA), Althea Mabayoje, Ellender Mathis, Quiana Mayo, Kate, Parker-Reilly, Callyn Priebe, Lashawn Robinson-Nuhu (Trinity Health Breast Outreach Coordinator), Lisa Rodgers (CHNCT), Carmen Teresa Rosario, Jenn Searles (CONNIE), Tracey Saucier, Erika Sharillo (Beacon Health Options), Sharon Sipps, Sheldon Toubman (Disability Rights CT) , Benita Toussaint, and Mark Vanacore (DMHAS)

1. Introductions and Announcements

-Co-Chair Janine Sullivan-Wiley convened the meeting at 1:04 PM via Zoom.
-Spanish translation Services were made available and the process described. All were advised that the meeting was being recorded.

2. Update on Public Health Emergency (PHE) – Bill Halsey, DSS:

The situation is still unchanged. Halsey described the implications of this for Medicaid:

- Because of and only during the Public Health Emergency, as determined by the Federal government, the CT Medicaid program gets an enhanced match and therefore cannot dis-enroll people from Medicaid. The number of people on Medicaid are thus much higher at this time. When the PHE ends, there will be a huge redetermination process which will be careful, deliberate, and take 12 months. There has been a lot of preparation at DSS for this.
- Telehealth has been expanded significantly. However, for behavioral health, one of the billing codes for audio-only services is dependent on there being a declared PHE. DSS is interested in retaining audio-only in certain, fairly rare, circumstances.

Questions and comments followed.

- Sheldon Toubman wanted to correct what he said at the last meeting: the Federal government said it would give 60 days, not 90 days. That would mean at the earliest mid-October. He added that while the Feds cannot reduce benefits during the PHE, before former president Trump left office, they added another exception for people on full-benefit Medicaid that QMB coverage (another Medicare savings program) alone is enough. He was disappointed that CMS did not rescind that.
- Kelly asked about food stamp coverage/benefit which have been higher during the PHE. What happens when it ends? Bill said he would look into that. Later in the meeting he responded in the chat that "SNAP benefits have been enhanced under the federally declared public health emergency. The SNAP enhancement will end when the federal government ends the public health emergency. Just to be really clear- only the enhancement will end at the end of the public health emergency."
- There was a question and concern about the new virus, monkeypox. Bill indicated that DPH is looking at that.

3. Making Advanced Directives- Kathy Flaherty

Janine introduced Kathy Flaherty, the Executive Director of Connecticut Legal Rights Project (CLRP). Kathy noted that she will provide documents for today's presentation afterwards.

Kathy began her presentation describing what a health care Advanced Directive is. Some of the major points of her presentation are below, including responses to questions asked.

(See also presentation, attached.)

- An **Advanced Directive (AD**) is a legal document that details a person's medical preferences, in writing, to be honored (wherever possible) if the person is unable at a point in time to advocate for themselves.
- It would include the designation of another person who would act on the person's behalf as needed: a Health Care Representative.
- It gives a voice to the person's choice.
- Who can create one: Anyone 18 or over with the capacity to make legal and medical decisions, including the nature and consequences of decisions… an informed decision.
- You cannot be forced to make an AD.
- Choosing a Health Care Representative: This should be a person you trust to make health care decisions for you, respecting your preferences and wishes- what they understand that you want based on conversations that you have had with them. This is a very important

decision. It cannot be your own doctor, or an employee at the healthcare facility unless it is someone you knew beforehand such as a relative.

-ADs and conservators:
  - An AD is not the same as conservatorship. The latter can be helpful but can seriously curtail a person's rights and choices. You can spell out who you would choose as a conservator in your AD.
  - Getting a conservator is a separate process through probate court. That application should include if there is an AD… which may mean that a conservator is not needed.
  - If the person already has a conservator, the conservator might have to do/sign the AD. It depends on what type of conservator it is. A conservator of estate cannot execute an AD but a conservator of person *might* be able to. It depends on the exact decree of the probate court and the rights retained by the individual.
  - If the person has a conservator, they should be involved at least to look at it.

-An AD should be developed when you are doing well. It kicks in at the point of need. The decisions that are made are much more comfortably done when the person is healthy. There should be a lot of conversation to make sure that the person and the health care representative have thought about and understand the preferences.

-It can contain as much or as little as you want. It might include such things as preferences regarding ECT, types of medications, or any aspect of health care. It can indicate certain things to be avoided (certain medications) or things that help (such as coloring, quiet surroundings, what steps to take that help).

-An AD should be mostly followed but may be constrained in some things such as request for a single room which may not be covered by your insurance.

-It is helpful but not required to have an attorney look at it.

-Differences between an AD and a WRAP (Wellness and Recovery Action Plan):
  - Both are planned in advance when well to use when less well.
  - An AD is a legal document, WRAP is not. But can be included in the AD.
  - It may include end of life decisions.

-Specific requirements for an AD:
  - Must include your signature and requires two witnesses (which cannot include the health care representative)
  - Be notarized and date-stamped

-It can be changed or cancelled at any time

-Some changes are automatic (such as removal of a spouse at divorce).

-There is an AD form on the CT Attorney General website. You can add to it as you wish.

-Only the pages that are there when signed and notarized are part of the official document.

-CT does not have special psychiatric ADs as do many other states, which separate out medical and psychiatric health care.

-There are special requirements for witnesses for persons living in a DMHAS or DDS facility.

-Having an AD does not solve all problems about treatments that are contrary to a person's wishes.
  - It can be overridden in an emergency
  - A court may authorize a conservator or facility to involuntarily medicate a person.

-While a health care representative is not required to live in CT, it is important that they can be readily reached. It is also important that they be a person who can handle decisions during a tough time.
-You should make copies of the notarized document and give that to all of the relevant people.
-CLRP is no longer able to have copies of the AD Workbook they developed, or cards. They are trying to convert that to an online document of the form and process that people could print out.
-Developing an AD is well-suited to pro-bono legal help.
-Cultural considerations should be part of an AD.
-A Living Will can be part of, or a kind of, an AD. Living Wills are more geared to end-of-life preferences and decisions.
-A person taking care of another is not the same as a conservator or necessarily having power of attorney. A healthcare representative is like having power of attorney for health care decisions.
-There are many, some new, ways of helping people with life choices, such as "supported decision-making."

Kathy Flaherty was thanked for her excellent presentation.

4. NEMT update:

Bill Halsey, DSS, provided some updated information as a follow-up to questions left unresolved at the last meeting.

-He read the trip rescue protocols as provided by Veyo. IF there is a rescue provider, they go out. IF there is not one, it goes to Veyo dispatch to match up with the nearest Independent Driver. As a last resort, they may also work with Lyft or Uber to provide a ride. There was a question about after-hours rides (e.g. to and from a sleep study.) Bill will forward that question to Veyo.
-Kristin Houter (DSS) will also follow-up regarding 24-hour operators.
-Althea reported that she still hears complaints about no-shows. Dissatisfaction with Veyo has led to people using more services from TRED (a local system) or Go-Gear (also local). Bill encouraged her to get names, dates and times so he could follow-up. He noted that DSS has looked very specifically at the location/address she referred to.

5. Update on – BHP Consumer/Family Advisory Council:

Report by Neva Caldwell, who thanked the chairs of this meeting. She also noted that Rod Winsted (DSS), who has retired, will be missed. Others agreed and asked Bill to please convey the very best wishes to Rod from Coordination of Care group.

-The July meeting had a presentation from Sharon Davis on Family First.
-The seventh annual iCAN conference will be on 9/22/22, from 8:30 AM-2:30 PM. They have decided to record all of the breakout sessions and allow all attendees to access them afterwards.
-The CTBHP is continuing community meetings, including about Children & Youth, HUSKY Health, and ASO meetings.

6. Other and New Business:

Members were asked to consider future topics. The following were suggested:

-DEI

-Community Services and how these are delivered in urban settings (it was suggested that providers and state agencies would have the knowledge and information to speak to this)

-Outreach to the community. How is this done? What is the flow? Consider ALL communities. How are the internet and social media used for this? What about other community (but not behavioral health) agencies such as Salvation Army programs?

-A suggestion that the Coordination of Care Committee do community conversations about this. Maybe a survey?

7. Adjournment: The Meeting was adjourned at 2:45 PM.

Next Meeting: 1:00 – 3:00 PM, **Wednesday**, September 28, 2022 via Zoom