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, November 22, 2022
1:00 PM – 3:00 PM
Via Zoom (hosted by Beacon Health Options)

Present on call:

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Staff: David Kaplan (BHP-OC)
Co-Chairs: Janine Sullivan-Wiley, Kelly Phenix, Sabra Mayo
Other participants: Rev. Robyn Anderson, Lois Berkowitz (DCF), Carlos Blanco (Beacon, translation services), Neva Caldwell (Chair-CFAC), Roberta Cook (BHCare), Sandy Czunas (Office of the State Comptroller), Kathy Flaherty (CLRP), Heather Gates (CHR), Bill Halsey (DSS), Brenetta Henry, Kristin Hunter (CT DSS) , Tanja Larsen (Community Child Guidance Clinic), Cory Ludington (CHNCT), Quiana Mayo, Yvonne Pallotto (DSS), Kate Parker-Reilly (CT Dental Health Partnership), Lashawn Robinson (Trinity Health of New England), Lisa Rogers (Community Health Network of Connecticut -CHNCT), Erika Sharillo (Beacon Health Options), Nancy Sienkowski (CHNCT), Stephanie Springer (DCF), Sheldon Toubman, Benita Toussaint, Mark Vanacore (DMHAS), Carleen Zambetti DMHAS

1. Introductions and Announcements

-Co-Chair Janine Sullivan-Wiley convened the meeting at 1:06 PM via Zoom.
-Spanish translation was 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 Public Health Emergency has been extended, but no known end date as of yet. DSS

continues efforts to be prepared for when that happens. Connecticut should be advised 60 days in advance that it's ending, at which point DSS will begin the 12-month process of redetermination. It was agreed to hold a place in the January agenda in case there is news by then.

3. Case Management, Care Coordination and Community Outreach:

Janine provided background on the process, ss this committee continues its exploration of care coordination and community outreach, with presentations by a variety of providers and individuals representing different parts of the state and different kinds of services. The overarching goal is to identify coordination and access across different populations; and practices that work, are effective and/or innovative.

Toward that end, the presentations this date were by Heather Gates, President/CEO CHR (Community Health Resources), and the Rev. Robyn Anderson, Ministerial Health Fellowship, Pastor of Blackwell Church, and provider of direct human services and advocacy.

Heather Gates, CHR, began with a presentation about the services offered through her agency that address these issues. CHR operates through eastern Connecticut, Hartford, New Britain, Bristol and through to the shoreline, although they are able to serve people from all around Connecticut. The agency is a CCBHC – a Certified Community Behavioral Health Clinic – a very specific model, part of a national initiative to build comprehensive systems of care for both children and adults. As such, the agency provides a wide range of services, which she described in some detail.

Their services include Mobile Crisis for both adult and children, adult outpatient and intensive outpatient, peer support and peer navigation, as well as DMHAS-funded services (for their target population) including Assertive Community Treatment Teams, Community Support Program, Behavioral Health Home, Peer and Care Coordination. They offer coordination within the behavioral health system and with external providers such as primary care physicians and hospitals. She sees having peers as a part of the behavioral health treatment team as critical to all services but especially for outpatient and intensive outpatient.

Overall, they do a lot of care coordination, noting that the needs of individuals are greater than just the behavioral health treatment needs. The job of CHR is to connect people to other services and components – linkages. These are sometimes now called social determinants of health – the things a person needs to have a comfortable and safe life.

The presentation was followed by questions, answers and comments as follows:

-There was concern about the population served at Whiting Forensic and Dutcher at CVH, that people there get the right mental health care. Heather noted that CHR is a Local Mental Health Authority, and as such, they are responsible to engage with any person (from their area) before they leave WF or Dutcher. Each area has a point person responsible for that - to follow the service plan from pre-to post-discharge.

-There was a concern about the low rates of working of people with mental health needs, and that low employment is based on ethnicity. Heather noted that one of the biggest challenges

can be that the services needed may not be available. Providers try to put together what they can within the available resources. It does not always work. Some people in the community are not getting what they need, especially in the area of residential services, although she noted that Connecticut is better than many other states in this respect.

-Concern about how we can connect services for overall health, especially for people who are African-American. Heather responded that is bigger than CHR, and depends on if they are notified about medical issues of people they are working with. Questioned about African-American males, Heather said that they track race etc. and compare the people they are serving to the demographics of that service area. To support this, they prioritize hiring of people of color, people who are bilingual and bicultural. They operate six methadone treatment programs within correctional facilities, where they have noted more trauma among African American and Latino people.

-One person said that in Hamden there is no real connection to the African-American community, a lack of information about health care, and no follow-up appointments. Heather said that happens all over – it is a real problem.

Heather then spoke about CHR's children, youth and family services:

-She emphasized that CHR is not an FQHC (Federally Qualified Health Center) but a behavioral health provider offering many evidence-based models. All of those models are for specific populations and conditions, and some have care-coordination embedded. Often people live in complicated situations and with life challenges, and so there needs to be coordination with all of the resources/providers. Some of these services are funded by Medicaid, DCF grant or both. The last provides the greatest flexibility.

-Outpatient services for children also includes federal funding (as a CCBH) to do care coordination to address health care needs such as smoking, drug use, exercise or stress. This is very successful.

-There are care coordinators with the crisis teams, usually dealing with multiple issues.

-There are specific Care Coordination programs for high-risk youth, and an intensive care coordination program is available for certain high-risk youth.

-All residential programs include care coordination. They have added follow-up after kids leave.

In general, within behavioral health services care coordination is as important as the therapeutic relationship with the clinician. Challenges with access remain.

Rev. Robyn Anderson then spoke about her program and spiritual services and how they relate especially to communities and individuals.

The Ministerial Health Fellowship is a faith-based, grass-roots organization with pastors and community leaders. Their focus is on health disparities, and getting out in the trenches. "The only one that can save us, is us." She said that every church in a community can and should take care of that community. As a grassroots organization, manpower is always a challenge.

-She noted the health impacts on communities of color, and the numbers dying of Covid. When they found that people did not go to regular clinics, they set up clinics in church in Middletown for vaccinations, and by going door-to-door. They have gotten over 25,000 people vaccinated.

-They developed wellness kits (thermometer, masks, hand sanitizer etc.) and information on

what was going on and what was available, including for people to understand their own insurance. Their model encourages that when a person connects to services, that person tries to help another.

-Team of case managers goes out to connect people with what they need and help start to finish as the process can be overwhelming.

-They have a program to address infant mortality and maternal care: "Pregnant with Possibilities." They also have doula services and work with mothers for up to a year. They help women meet their goals. Rev Anderson said that unfortunately things are still in the same place.

-They help people navigate and trust the medical system.

-Community Health Workers are in teams.

-They work with barbershops and hairdressers to get out information.

-She emphasized meeting people where they are, and to make sure that at the end they are not at the same place as when they met.

-Her biggest concern: that these services continue after the pandemic ends. There are issues of health equity and systemic racism. People want to get help from people who "look like them" in all settings, and to be treated with dignity and respect. Underneath mental health, substance use and trauma is racism.

-She is excited for churches to get funding to provide services there, including mental health, psychiatrists, medication assisted treatment. There should be partnerships between grassroots agencies and larger organizations.

Her presentation was followed by questions and comments including:

- One member noted that there are challenges with people getting services and overlaps with all of the needs people have. It's very tough. Organizations don't want to share. Rev. Anderson agreed. "We need to work together. Large and grassroots organizations need to work together."

-People need access to people who understand their needs.

-There was a question about what funding is available for those services not covered by Medicaid, and for those people who might have housing needs but are just over income limits. Rev. Anderson noted that there is no longer much low-income housing. Old ones have been demolished but not replaced. There are too few Section 8 Vouchers. Even $5 over can mean a person loses housing or the cost goes up and they can't afford it anymore. It was suggested that the limit increase to 300% of the FPL, or people can get stuck in poverty.

-Physical and oral health impact all health therefore there should be more support for oral health, such as two cleanings a year.

-Rev. Anderson noted that her program has helped 25 people to a better place financially with the American Rescue Act, addressing budget, credit repair and savings. That is not a band aid but moving people to a better place.

-Some of the special funding sources have been the 1st Century Fund for $25,000 for five years. Case management and crisis services have used FEMA and then DMHAS funding, but that is now ending. There was a federal grant through the office of minority health for doula and maternal health. Bill Halsey was asked if doulas could be funded by DSS.

-There was a concern that grassroots organizations can't get the funding they need to work in the community.

-There was agreement with these concerns.

-Heather Gates thanked the organizations embedded in the community and agreed that we all have to work together. Medicaid funding is excellent, but the challenge is that it is a health care insurance program, with federal regulations that must be met. That can mean losing the benefits of community organizations. The challenge is how to bring them together. Rev. Anderson agreed that Medicaid is not the answer to that. To address health equity can mean relinquishing the old ways of doing things. People want to be able to take care of themselves.

Several themes were noted from this conversation:
-Funding for community-based services is essential and needs to be strong and adequate.
-Coordination of care is essential across all services and people.
-Resources are needed for all levels of care, including good housing.
-Community has to be involved in this work.
-Attention is needed to investment especially for people of color.
-People who get services should be able to say what they need in their communities.
-Funders should be brought together.
-"Nothing about us without us."
-Peers should be utilized throughout.
-Regulatory barriers – who can do what where – are hugely problematic in bridging the gaps to work with grassroots organizations and groups. Large and community organizations are otherwise pitted against one another rather than partnering together. A lot of good ideas can't be implemented because of funding and regulatory issues, such as services being provided outside of a clinical setting.
-Smaller organizations don't have the staff or capacity to devote to fund-raising. The administrative and data requirements can also be a barrier.
-Services can become entrenched in how things have always been done, even when other, non-traditional methods may have better outcomes. "Evidence-based practices" versus new and innovative. Change can be restricted by what "counts" within the agency.
-Power inequity needs to be considered in collaboration between large and small organizations. Grassroots groups do not want to be "taken over." It must be a true partnership.
-How to foster partnerships:
    - Has to be intentional, what they hope to achieve.
    - While there is a lot done already, there needs to be more.
    - Regulations that support both grassroots and larger organizations
-Legislative changes may be needed.
-A positive is that people and organizations are trying to diversify but this can't be just because it is required – it has to be valued.

Suggestions from the group in the chat included:
-Assess barriers and create ways to overcome them by creative solutions. People with lived experience often have simple answers.
-Funding has to lift restrictions to make for more open access.
-Hispanic community: Utilize social engagement from the perspective of the grass root organizations that could provide direct knowledge about the community they serve.

4. **Update on – BHP Consumer/Family Advisory Council:**
   Brenetta reported that they had an iCAN luncheon to celebrate the presenters. She noted that the conference did lead to new partnerships.

5. **Other and New Business:**
   None.

6. **Adjournment:** The Meeting was adjourned at 3:00 PM

Useful or shared links and information from this meeting:

- Responding to a question about Medicaid coverage for doulas: Bill Halsey reported in the chat that Doulas are not covered yet, but the plan is to cover them under our maternity bundle: https://portal.ct.gov/DSS/Health-And-Home-Care/HUSKY-Maternity-Bundle

Next Meeting: 1:00 – 3:00 PM, **WEDNESDAY, January 25, 2023 via Zoom**