Tow Youth Justice Institute

Making connections. Informing solutions.

TCB April 2024 Meeting Minutes
April 3, 2024
2:00PM-3:30PM
Virtual: Zoom

Attendance

Alice Forrester
Angel Quiros
Ashley Hampton
Carrie Bourdon
Carolyn Grandell
Catherine Foley Geib
Ceci Maher
Claudio Gualtieri
Cristin McMarthy Vahey
Derrick Gordon
Edith Boyle
Howard Sovronsky
Jeffrey Vanderploeg
Jeana Bracey
Jeanne Milstein
Jillian Gilchrest
Jody Terranova
Jodi Hill-Lilly
Kimberly Karanda
Lisa Seminara
Lorna Thomas-Farquharson
Michael D. Powers
Michelle Scott
Michelle Anderson
Mickey Kramer
Yann Poncin
Shari L. Shapiro
Sinthia Sone-Moyano
Tammy Freeberg
Tammy Exum
Yvonne Pallotto
Christina D.Ghio

TYJI Staff

Aishwarya Sreenivasan
Erika Nowakowski
Izarelli Mendieta-Martinez
Karen Snyder

Welcome and Introductions

Senator Ceci Maher, Claudio Gualtieri, and Tammy Exum welcomed all attendees to the meeting. Ceci Maher stated that the meeting was not conducted in person due to unavailability of meeting rooms.

Overview of the Meeting

During the April meeting, Jennifer Krom, Director of Autism Services at Carelon Behavioral Health, presented on HUSKY and Connecticut's Medicaid behavioral health autism services. Erika Nowakowski, Director of the Tow Youth Justice Institute, discussed updates from previous TCB meetings. Additionally, Erika Nowakowski and Karen Snyder, an independent consultant, presented on the common challenges and recommendations highlighted in previous TCB presentations from September 2023 to March 2024.

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Updates

Erika Nowakowski provided updates on upcoming events. The TCB strategic planning meeting is scheduled for June 3, 2024, from 8:30 AM to 4:00 PM at Middlesex Community College. Breakfast and lunch will be provided. Due to the full-day meeting, there will be no TCB meeting in June. Additionally, she mentioned that the Pathways to Success: Trailblazers and Innovators in Youth Justice Conference will take place on May 22, 2024, from 8:30 AM to 5:00 PM at the Connecticut Convention Center.

HUSKY/CT Medicaid BH Autism Services

Jennifer Krom, LPC of Carelon Behavioral Health, continued last month's presentation on HUSKY Autism Services, detailing Medicaid coverage for eligible individuals under 21 with HUSKY A, C, or D. Diagnostic testing is covered if no diagnosis exists, and upon diagnosis, families can access behavior assessments and community providers through Carelon care coordinators and peer specialists. Services are flexible, occurring at home, in centers, with preferred staff, and at convenient times for families.

Medicaid services commence with the behavior assessment, which includes observations in various community settings to view an array of behaviors. A board-certified behavior analyst (BCBA) then develops treatment plans with behavior reduction and skill enhancement recommendations, estimating the hours needed for successful intervention. This recommendation is passed to Carelon's clinical care managers for authorization. Further, group intervention led by BCBA and driven by a social skills assessment may also be authorized by Carelon staff.

Carelon staff can authorize indirect time for program book development, which is the documentation containing crisis plans, data sheets, and other information families refer to when working with the child. In addition to the book, a one-sheet crisis plan is also created for families. Provider enrollment for Autism treatment is up to 1,000 individuals with BCBA or licensed clinicians and 143 agencies. As of April 1, 2024, 469 individuals had been reported as authorized for diagnostic evaluations, 4,620 are authorized to receive direct individual treatment services, and 82 individuals are authorized to receive group treatment intervention, with increasing numbers over time. Under Medicaid benefits, 3-year-olds constitute the largest group of individuals initiating services, indicating that children are connected with a Medicaid-funded provider after discharge from birth to 3 services.

Carelon Behavioral Health Autism Spectrum Disorder care coordinators and peer specialists are available to all individuals with a Medicaid plan, regardless of package or age. Staff are regionally assigned and participate in community meetings. Two staff members are assigned to support individuals in the emergency department directly.

Jennifer Krom highlights the recent successes of Carelon, including the increase in providers and clinic/center-based services, as well as increasing attendance to services. Providers also report that staff retention has increased since reporting more to center-based services. Challenges include staffing shortages, particularly bilingual staff, and long waitlists, especially near Rhode Island. Recommendations from providers include reviews of Behavior Technician qualifications and aligning them with other state agencies, which host lower qualifications than providers. Carelon is looking into incentivizing Registered Behavior Technician training.

Family therapy and sibling support are not specifically authorized under Medicaid, but Carelon helps connect families with community services offering such support, including groups for siblings and parents. Carelon works to connect families with other funded or free services. A question about the inclusion of school providers was raised. The Medicaid benefit may be contacted by some schools, but Carelon does not manage those authorizations; these are solely funded through the school. Contracts with Carelon allow in-home and community-based care coordination to be paid for as part of the Medicaid benefit. Another question was raised regarding the 10% metric of in-home care oversight and how the change of qualifications for staff may change oversight requirements. Oversight services were determined by research recommendations and insurance mandates in 2015 following data records, establishing at least 10% oversight, with higher percentages allowed through justification. A question was raised about the locality of coverage and a map of providers. Currently, an interactive map of providers is in the works. The most limited region of services is along the Rhode Island border, DCF region 3. The upper Lichfield area is also a difficult region to cover at the moment. The map's release will be posted following the approval of the state providers. Currently, a provider list is compiled on a spreadsheet and located on the CTBHP website. A question regarding data collection from families was raised whether families are receiving everything they need and if information on family needs is being collected. Similar information is being collected through needs assessments by care coordinators and peer specialists. A final question was raised on the time frame between the request and the time a BCBA begins services. The data presented is authorization-based and not claims-based services. Regarding wait times, it is based on provider waitlists and providers are responsible for managing their own waitlists.

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TCB Common Themes: September 2023-March 2024

Erika Nowakowski and Karen Synder presented the common challenges and recommendations presented to the TCB from September 2023 to March 2024. After the presentation, a finalized document summarizing updates was expected to be shared. Erika and her staff have been working with previous presenters to collect updates and send out a summary of any updates from presenters within this document.

Karen Snyder presented the details around the themes, including challenges, examples, and recommendations from providers and state agencies. Themes included fiscal, workforce, data and information sharing, service delivery, access and equity, and family and caregiver support.

Fiscal challenges stemmed from gaps between Medicaid rates, grant allocations, and essential mental health services expenses, hindering staff recruitment and retention and contributing to waitlists. An example of this is the underfunding and competitive grant environment that poses financial challenges for organizations Recommendations included there is advocacy for commercial plans to include coverage for intensive or in-home care services and establish a billing mechanism that allows for these services to be present. It is also recommended that Medicaid reimbursement rates and grant funding be increased to reflect the actual cost of providing services, including wages for staff and accounting for inflation.

Workforce issues involved low wages and high stress or burnout of clinicians. Clinicians who are bilingual or specialize in neuro-disorders are particularly difficult to recruit due to the aforementioned challenges. Recommendations included adjusting Medicaid rates for competitive salaries and incentives, implementing professional development programs, enhancing compensation packages for outpatient clinics, promoting individuals with lived experience in peer support services, and aligning Connecticut DSS Medicaid standards with commercial insurance requirements.

Data and information sharing challenges arose from inconsistent data collection, leading to unequal allocation of resources to meet the most pressing mental health needs. Recommendations for this issue include strengthening the overall infrastructure, including the referral process, information sharing, and service coordination, to enhance efficiency and effectiveness by giving a baseline for the

next level, considering reimbursement incentives for data reporting, and prioritizing and identity funding to improve accountability.

Service delivery challenges included the demand for intermediate levels of care exceeding available providers' capacity, creating lengthy waitlists and service delays, and limited access to timely mental health services. As patient volume increases, clinician workload within a fixed timeframe also increases, leading to burnout and turnover in staff. The recommended steps to overcome these challenges are to invest in expanding service capacity to meet the increasing demand, embrace telehealth, increase funding for intensive treatment programs, and collaborate with stakeholders like government agencies, healthcare providers, advocacy groups, and community organizations to address systemic challenges.

Access and equity challenges involve barriers faced by certain populations due to coverage limitations or affordability issues. Individuals in underserved areas may have limited access to mental health services because their locality determines their ability to access various service providers. Recommendations to address a lack of equitable access are to revisit Medicaid reimbursement strategies for pre-service actions, including initial phone calls, insurance verifications, and intakes that prevent families from accessing providers and that place stress on provider resources. Further, to increase access to services, it is crucial to invest in outreach and engagement efforts to educate individuals on mental health services and potentially reduce the stigma surrounding mental illnesses. Transportation challenges, supportive work environments, and culturally competent care are critical factors in promoting better access for providers and clients.

Family and caregiver support challenges included delayed diagnoses and limited service access for disadvantaged families, particularly those of color. Late diagnoses also delay early intervention and the use of appropriately timed services. To tackle this challenge, it is recommended that funding models prioritize family-based, needs-based approaches and revise reimbursement rates to reflect the actual costs of care. Investing in expanding access to comprehensive care coordination for all families is also recommended, ensuring compensation for providers.

Key takeaways emphasized the need for local solutions, communication, coordination, and collaboration between state agencies, with continued discussions on trauma-informed care and Adverse Childhood Experiences evaluations. Further, the following steps require that state agencies and existing mental health

committees collaborate, discuss financial solutions, and implement sustainable services.

A comment regarding a relevant bill was discussed following the presentation. Bill SB-217 establishes a universal intake form that addresses medical history, treatment history, condition history, prescription history, provider support, treatment being sought, as well as any other questions the workgroup will be developing and brings together the commissioner of public health, the Department of Children and Families, and the Department of Mental Health and Addiction Services as a working group. Several more statements were added regarding the collaborative piece. The collaborative approach ensures a comprehensive, efficient strategy for creating the most robust mental health support system. Participants emphasize the 3 C's: communication, coordination, and collaboration, which were mentioned in the participation.

Next Meeting:

Virtual: Zoom
Date: May 01, 2024
Time: 2:00 PM – 3:30 PM