Indiana Behavioral Health Commission
Continuity of Care Subgroup 4.22.21 (1:30 p.m. EDT)
https://www.in.gov/fssa/dmha/indiana-behavioral-health-commission/
https://www.youtube.com/watch?v=YQEDHiC4Q6o

Attendees:

Rachel Halleck, Steve McCaffrey, Matt Brooks, Mimi Gardener, Barbara Scott, Scott Fadness, Kelsi Linville, Amy Brinkley

Unable to Attend: Jay Chaudhary, Tim Kelly, Carrie Cadwell

Subgroup Charge

This group will examine the behavioral health system through the eyes of a person's journey through various aspects of that system, with a focus on identifying significant gaps, barriers and opportunities to integrate and/or coordinate care throughout the continuum of care. The goal is to create a user-friendly system that significantly improves current outcomes by providing rapid access to high quality prevention, early intervention and treatment as early as possible in the disease progression.

The Following Items Were Discussed:

1. **Introductions**, (each persons' interest and expertise in the area of continuity of care)
    a. R. Halleck set the stage, reviewed the agenda verbally, and discussed the process flow of the meeting.
    b. This subgroup has a primary goal of identifying recommendations for the Behavioral Health Commission related to continuity of care.
    c. This group will report out to the larger group and is a mini – board to the larger group.

2. R**eview legislation and assessment areas for subgroup**
    a. R. Halleck read through the subgroup charge for this group (wrong language actually in the slide but was posted to the chat by Amy B) and is laid out above.
    b. R. Halleck discussed the two reports required in the legislation, the first which was due in October 2020. Not much there but next report is due October 2022 and the goal is to make headway between now and the next report.
    c. R. Halleck detailed the requirements in the legislation needed related to assessment and inventory, Youth and Families, System Design and Access, and Funding and Data
    d. R. Halleck detailed the additional tasks for the commission which include reviewing mental health and substance abuse funding streams, making recommendations concerning funding priorities, and funding levels for mental health programs including establishing the cost of untreated mental illness and evaluating the efficacy of the Data

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Assessment Registry for Mental Health and Addiction (DARMHA) and making recommendations on improving Indiana's current assessment and data system.

e. R. Halleck provided the overview of the assessment areas that were mandatory which were funding, access to care, and system design with a focus on equity, SDOH, data, integration, administration red tape, utilization of technology, and strategies designed to encourage collaboration, transparency, and innovation.

Operational Definition of Continuity of Care (Open Discussion – Rachel Halleck)

f. K. Adams continuity of care exists, one wheel with lots of spokes, teaching clients self-management, identifying cracks, and where are the collaboration and communication breakdowns happening.
g. S. McCaffrey simple, no wrong door and whatever door you go in you should be able to get what you need. Too many silos and lack of communication is the breakdown. Assessment, service plan, and then you should get what you need but what's happening is that you only get what is available in that location verses what the person needs.
h. M.Brooks need a system that allows for access in a sustainable way. Not a system that is one and done but need a system that is designed to target continuation of care not just access to care.
i. R. Halleck clients needing to transition between providers when clients do not meet the specific needs and the expansion of 3.5 beds has created a huge shortage of the next step down 3.1 beds so many going to recovery residences and causing people to go back to the place they were perhaps trying to get out of. Many people don't realize how long it will take and what it will take when engaging the system and adding the racial equity lens and LGBTQ population the gaps get magnified. So many providers doing a fraction of the continuum feels fragmented for the people accessing the system.
j. B. Scott the per diem rate is not sustainable so people do not want to provide it (3.1 as an example). Posed the question of how 'civil commitments' are being used and how are they being monitored and tracked. Do we have inventory of this information? Civil commitments require a higher level of care that just isn't there at times and it's a struggle. State psychiatric hospitals release clients are sicker than 30 years ago and for some individuals living in the community and the current availability of services is not working.
k. K. Adams and sometimes they are violent and how do providers staff group homes to accommodate the needs for the violence.

l. R. Halleck please contact DMHA if needed resources or support related to these issues. Numbers from Medicaid are showing that when people leave 3.5 services then are dropping completely.

3. Data needs

a. R. Halleck lots of anecdotes but what data do we need? What do we need to get a baseline data to start with, and what information do we need and have access to target our focus areas. Is this a need and do we need to pick a area and just go forward?
b. M. Brooks praised Katy Adams for helping pass legislation bill that will authorize life skills or any service array that is not part of the 3.1 service array and will be eligible to run concurrently with the services. The bill passed today. 49-0. The reason the 3.1 is not being used and the reason for the drop off is because the business model for sustainability is not there. Need to create opportunities for service arrays that are designed to work and to build the business model.
c. K. Adams you can build something that looks good on paper but may not make a difference in the continuity of care. Could be the client choice that they didn't step down not necessarily always that it's not offered. Data could be interesting but not sure what it really tell us.
d. S. McCaffrey we all agree that we have systemic barriers and which are mainly financially driven. Addressing this would be the biggest fix we could do to address the need. We are incentivized to do the wrong and it should be the other way around.
e. K. Adams how does SDOH fit in and does it cause people to fall through the cracks. Communities need more resources?
f. M. Gardener SDOH is a big issue in the hospitals she shared her experience at the hospital. They targeted some people seeking shelter and food and come to the hospital. High utilizers can tell us a lot on why people are coming back. Follow them help open doors for different systems and help deflect when people want hospital but need something else. Funded by the state in Maryland through an RFP that also provided a warm handoff to people being discharged from the state hospitals and an intensive case management program that helped people to access the SDOH needs.
g. M. Brooks the federal health home is designed to do that too. Is it a rehab situation or a habilitation. Need to delineate. AMHH was a habilitation and MRO was rehabilitation a lot of people fall into one or the other and trying to identify where they fit. In 2010 life skills and MRO was a rehabilitation and having people funneled into the programs was good intentioned but didn't play out well. When they were designed a lack of provider engagement existed and there is no business model so it's not being utilized.

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h. B. Scott recalls the experience and excitement over the habilitation and the algorithm then cut everyone out and ended up allowing for all of 4 people to access the program within the entire agency. Overlap in mental health wellbeing subgroup talked about the same things. What is the key to transitions and it is engagement. The business model is not there to support CHW's or peers even though they are the special sauce.
i. A. Brinkley utilizing recovery capital scales could be used for mental health and addiction scales across MH and SUD's and early conversations are happening within DMHA around this now. Would need to identify where in our system we could use the recovery scales. Discussed the lived experienced survey feedback which defines barriers related to SAMHSA's dimensions of recovery in people's own words. Strategically placing and using these scales could really help identify these needs related to SDOH.
j. B. Scott we in the industry talk so much about the need of services, but people don't think they need things in terms of 'services', for people the need is housing, food, shelter etc… our model is disease based and we look for a diagnosis and the cure is meds or treatment and education and the paradigm is not social determinants or recovery capital.
k. R. Halleck by nature when struggling with symptoms you are in survival mode and you have to focus on basic needs (Maslow's Hierarchy of needs) and engagement to provider services is the first thing to fall off. If we do it intentionally and mindfully with IHIE cross collaboration with jails, CMHC's, and providers, effectively could help with the cross collaboration, data, and information pathway. This could address the intake assessments that happen and retraumatize over and over at the jails, providers, CMHC's, and the trauma and attrition caused by that is a real issue. Clients say they didn't' go back to counseling because they don't want to sit through two hour assessments all over again. Data sharing has a lot of potential.
l. K. Adams loves the recovery capital scales and they use it but if we add something we need to take something out. We need to take the frustration away for people regarding the hoops people jump through to get meds and get treatment. Peers are the secret sauce.
m. R. Halleck how could we take the housing approach in the treatment area?
n. S. Fadness if we were to aspire to build a system that is intentionally built to take the action away from the person who is seeking services. What area of the state is not tied to the federal government that we have the ability to change and recreate to our needs related to these issues around services and programs in Indiana. Needs to know our bounds here in Indiana, what is our sandbox?

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o. R. Halleck accreditation entities have some barriers – interested in convening with CARF and JCAHO have very stringent rules about what goes into a treatment plan and assessment plan and the providers have to answer to so many state agencies and few of us are talking to each other around that level of detail. Another thing is budget neutrality is one of the first walls we can hit. Lots of opportunity to strategize.
p. M. Brooks the budget has another 100 million dollars for MH dollars. Not lots of guard rails some flexibility. 50 per year.
q. S. Fadness for the business model how would you rank them on who is creating the most barriers or prescriptiveness that is creating the most issues.
r. M. Brooks it's not just state and federal bodies it's our own agencies too. DMHA is interested in transformation a new system and collaborations are happening now. Collaboration efforts could help us overcome it. 1468 is going to allow for an early intake and assessment rate.
s. B. Scott the number one public MH funding is Medicaid, our county commissioners are tired of hearing about Medicaid but that defines services. There are waivers and state plan amendments and there are more opportunities there now to do innovative stuff then ever before. Some other states have been a bit more creative so there is federal flexibility.
t. S. Fadness who owns the responsibility and drives the continuity of care outcomes under the current system.
u. M. Brooks the CMHC's because that's a requirement of certification and accreditation. In order to have continuity you have to have a broad base of services to meet needs and can't turn people away.
v. R. Halleck many or most of the CMHC's have the full continuum (some do not) where it gets complicated they have to have a documented partnership to fill the continuum. It gets fragmented when the client ahs to go to the hospital to get an inpatient stay and the client has to relay to the CMHC the outcomes and go through the intake process again. People get referred to detox and are told to contact them back after detox etc.. and this is where continuity of care difficulty occurs. Case management and utilization of peers (bucket). Anthem has a pilot program for high utilizers to get a case manager and wrap around services to help the person get connected to resources and stabilized in the community. Could replicate something similar with peers.
w. M. Gardener this is the same program we did in Maryland. Case managers that get people followed to the next level of care and transition the client effectively to not lose engagement and get them connected to services they need. That program has funding available for SDOH needs.

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x. R. Halleck creating a continuity of care system that allows for that one person who connects people to various providers helps reduce the dropping out of services and maintain engagement in treatment. A (care coordinator or peer) can be a client's constant connection to reduce dropping out of services and falling in the gaps within the system.
y. S. McCaffrey the people we are talking about interact with so many different systems that we have to have someone that helps them navigate through the systems collectively. Connect all the systems including primary care for people is what needs to happen and they need more touches and have less capability to do it.
z. K. Adams loves the peers but they don't bill in a way that doesn't pay for itself. Doesn't have to make money but needs to pay for itself.
aa. M. Brooks the peer inclusion for mobile crisis has peer utilization but there is a concern about the reimbursement.
bb. R. Halleck utilization of peers in our mental health development has been a bit behind.
cc. B. Scott we are facing a decade of workforce depletion. Open positions for a whole year with no applicants. Research shows people with lived experience connect with our population better than licensed folks' but we can't employ them because the pay range is too small. It's essential for us to quality behavioral health services with good outcomes by using extenders (non-degreed' individuals).
dd. S. McCaffrey agreed with Barb not just peer but there is a whole group of people that could do things that right now only licensed people can do.

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Broad Categories of Exploration

1. Case management /Peer and Community Health Worker connection
2. Maintaining engagement / SDOH
3. Data connectivity
4. Recovery capital scales
5. Crisis stabilization and intervention

Action Items

1. Everyone to consider whether they are open to chairing or co-chairing this subgroup. For anyone NOT interested who wants to opt out please email Rachel, Amy, or Kelsi no later than Monday April 26th if they do "NOT" want to be a chair/co-chair for the subgroup.
2. Next a link will be sent out by Amy, Kelsi, or Rachel that will include all names that are left for the commission to vote on a chair/co-chair within the next few weeks
3. Next meeting will be scheduled within 2 months
4. Each person to start thinking individually about next steps which include:
    a. Selecting focus areas for this subgroup
    b. Decide what this subgroup needs to review
    c. Figure out where we need to get more information
    d. Identify low hanging fruit for short term change
    e. Figure out how we want to move forward to develop what our recommendations are going to be for the Commission

After meeting via email:

- Matt Brooks opted out of chair positions
- Barb Scott opted out of chair but offered to co-chair
- Matt Brooks pointed out that May 31 was a holiday
- Doodle Poll sent with co chair and chair polls