

**Meeting Minutes of
The Governor's Council on Behavioral Health
1:00 P.M., Tuesday, June 13, 2006**

The Governor's Council on Behavioral Health met at 1:05 p.m. on Tuesday, June 13, 2006, in Barry Hall's Conference Room 126, 14 Harrington Road, Cranston, Rhode Island.

Members Present: Richard Leclerc, Chair; Carrie Blake; Linda Bryan; Scotti DiDonato, President Elect of the Mental Health Association of Rhode Island (MHA); Diane Dwyer; Mitch Henderson; Joseph Le; Neil Corkery; H. Reed Cosper; and Representative Bruce Long.

Ex-Officio Members Present: Craig Stenning and Gene Nadeau, MHRH; Janet Anderson, George McCahey, Jeanne Smith, Carol Fox, John O'Reilly, Virginia Stack, and Frank Pace, DCYF; Fred Friedman, DOC; and Kenneth Swanson, Department of Education.

Guests: Maria Sekac, Kathy Ullrich, and Jason Martiesian, United Health; and Jill Beckwith Rhode Island Kids Count.

Staff: Corinna Roy, Charles Williams, Kristen Quinlan, and Mary Ann Nassa.

Once a quorum was established, the Chair, Richard Leclerc, called the meeting to order at 1:05 p.m. After introductions were conducted, Richard entertained a motion to accept the Minutes of May 11, 2006. Linda Bryan stated that a comment that she made to Ellen Nelson, Director, MHRH, regarding the housing of Developmental Disabilities was not reflected in the minutes. Richard asked that Linda provide her comments in writing to Corinna Roy so that they can be inserted. Richard stated that the minutes are not a transcript and every discussion may not be included, but a comment regarding a certain point can be included. Linda stated that she feels it is a huge issue that there is a housing shortage in Rhode Island. Linda also stated that Craig Stenning did not go into detail but stated at the May 11 meeting that they are working on that issue.

With the assumption that comments reflect what Linda Bryan stated, Bruce Long moved to accept the Minutes and Carrie Blake seconded the motion. All were in favor, and the minutes were approved as amended.

UNITED HEALTH CARE BEHAVIORAL HEALTH BENEFITS

Richard introduced **Maria Sekac, Director of Clinical Policy and Standards for United Behavioral Health**, to talk about subscriber benefits of United Health. Maria then introduced her colleagues **Kathy Ullrich, Network Manager for United Behavioral Healthcare (UBH)**, who is primary responsible for the development of network and maintenance of network in Rhode Island, and **Jason Martiesian, Director of Government Relations for United Healthcare New England**.

Maria stated that she had reviewed the minutes of the Blue Cross presentation to the Council and that she would use it as a model for her presentation. Maria indicated that she would be talking about outpatient benefits and the outpatient process that was recently rolled out across the country and in Rhode Island, along with the network status and what is happening in the network, and how United is working to coordinate medical and behavioral healthcare.

Maria stated that in general it is difficult to talk about benefit plans or United Healthcare's Behavioral Health benefits because they vary by employers' needs. In general United's benefits are compliant with state mandates and regulatory requirements.

Maria chose to focus on the administration of the benefits and UBH's approach to how they manage the benefits, along with their new outpatient process. She stated that back in December 1, 2005 they rolled out a new model and a new process for managing outpatient benefits. At that time they discontinued the requirement for providers to submit treatment plans and in doing that they

discontinued the concurrent review process. The new process is intended to facilitate members' access to services. The member is required to call United to inform them that they are accessing care. If they have a particular provider in mind, United enters an "open authorization" that is good for one year; and during that year, the member is able to see that provider or any other provider who is in the network without a treatment plan process. If the member needs assistance with choosing a provider, United will facilitate that. This model is available across all of United Healthcare products.

Subsequently, United provides a "Wellness Survey." United asks the providers to have the member complete the survey at the initial session or reasonably close and that it be faxed to United. If the member completes it, it gives United a baseline sense of how the patient is feeling and the services they are accessing. Once it is faxed to United, the survey is scored. In that scoring some members may be identified as being at high or increased risk for hospitalization. Severe depression and substance abuse are the foremost categories putting members at high risk of hospitalization. When the surveys are scored on those members that are at higher risk, United will follow up with the provider and alert them to those facts. Before rolling out the program, United met with representatives of the provider community in Rhode Island in order to get their input and thoughts about it. So far, the process has been well received both here and across the country. Maria stated that it has established a more cooperative relationship as well as a clinical process that allows United to intervene with those people who really are at risk.

George McCahey asked Maria if she would explain the reliability or science behind the survey tool. Maria stated that it has been validated by the UBH's behavioral health sciences research group.

Maria stated that the tool identifies those at risk for hospitalization, those with substance abuse issues, some who are disabled from work, some with child-related problems and caregiver's strain on parents or families when children experience behavioral health problems. She stated that there are interventions for each of those scenarios and all of them start with contacting the provider first.

George asked how the scoring is accomplished. Maria stated that it is scanned, scored and entered into the record and then clinicians review the results. Carrie Blake asked if the member is aware of what they are doing with the survey. Maria stated that it is totally voluntary, and they ask that the provider ask the member to complete the survey.

Neil Corkery asked who United met with in the community and is there a sign-off for the providers indicating it had been offered to the member. Kathy Ullrich stated the provider is asked to send it in even if the member did not fill it out so that they can maintain a record that it was offered to the member, but it was not completed. Maria stated that they had met with the Psychiatric Society; NASW; Michael Silva, M.D., Medical Director of the Providence Center; and Dr. Wall. Neil asked if any substance abuse providers were included. Maria stated that she didn't think so. Neil asked if it is a clinical assessment and why is the insurer asking these questions. Maria stated that it is a baseline survey that provides clinical information on how the patient is doing when they start treatment. She stated that United offers some value in the management of members' care to ensure that it is the correct care, that it is going well and that they are offering what they need to in terms of the members' benefits. The provider uses this baseline survey as their assessment and as part of the regimen. United receives that information, and over time they are able to give providers feedback on how their patients are doing in the aggregate, not individually.

Mitch Henderson asked how long it takes to fill out the survey and if it detracts from the initial session. Maria stated that most providers give it to the members in the waiting room, and it takes approximately ten to fifteen minutes to complete. Kathy Ullrich stated that many providers use it for their non-United clients because they find that it is a very useful tool for that first session.

Richard Leclerc requested a copy of the survey of both the child and the adult version for the Council's review. Maria will e-mail it to Corinna Roy.

Reed Cospier questioned United's relations with community mental health support services. Maria stated that United contracts with all of the community mental health centers in Rhode Island and that they are very supportive of building community support programs. Reed asked if they funded community support services for a spouse of a disabled person. Maria stated that United has contracts for case management services with the community mental health centers and added that United is very supportive of building all kinds of community transition services and feels they are making a huge effort particularly around children's services to contract with whatever is available.

Janet Anderson asked if the survey is used in both public and private settings and Maria stated that it was. Maria stated that a follow-up survey is conducted after six months. That survey is sent to the member directly versus through the provider. This survey gives United outcome information about how the members are doing in treatment and what has been successful. The anticipated percentage of response with the six-month survey is usually about 30 percent of the original number surveyed. Because it was initiated in December 2005, the initial survey is under 40 percent, and now that the six-months are coming up, they will determine that response rate soon. Maria stated that it is their intent to aggregate the information and share that information with the providers.

Fred Friedman stated that when visiting United's website, it appears to have several providers available, but when you go to find that provider, you can't find them. Kathy Ullrich stated that to date there are over 1,100 providers available in the network and a fair number of those providers are hospital-based only. United is trying to do a better job internally in identifying those hospital-based only providers so that there is no confusion in referring anyone to them. Kathy stated that one of her current goals is to increase the M.D. availability especially for children. She anticipates a more complete list of providers by August. Kathy expressed the difficulties with medication management for members with physician access, and they have increased the network to include nurses with prescriptive privileges. There are now over fifty nurses in Rhode Island with those privileges. That is another resource that they are trying to get their care advocates to access more.

Maria stated that as of April, UBH implemented a training program for all care advocates at all sites across the county around a philosophical change with their traditional care managers called "Care Advocacy." The basic principle is related to identifying risks at all levels of care. United's staff is provided with educational, web-based resources that can be passed on to members. Staff are asked to educate members about what good care is and guidelines for that care. The resources teach clients how to talk to providers and how to make sure that they recognize that what they are receiving is meeting their needs. United audits their staff to make sure that they are engaging with members and providers to coordinate care and to maintain internal web-information to enhance and include community organizations, member-driven organizations, support groups and other resources.

Maria stated that United Healthcare is a large organization and the above described philosophical shift creates a focus for identifying those members who have co-occurring medical conditions. United strives to be better at working with those members, and better at identifying providers who have expertise in treating people with medical problems and are most at risk for decompensation for being hospitalized and in general for being vulnerable. United has several programs designed around medical/behavioral integration or holistic services and have developed much better connections with their sister companies within United Healthcare.

Linda Bryan asked if the same rules apply to out-of-network providers other than meeting the deductible and the eighty percent coverage as far as the new model described. Maria stated that not all out-of-network is the same. For those individuals who have benefits for out-of-network coverage, then it would be similar. United reaches out to out-of-network providers more closely. They do this to protect their members because those providers may not be credentialed and therefore, United has a responsibility for making sure that the care is adequate. Linda described the situation with psychiatrists in Rhode Island, stating that at one time they were in the network, but decided not to

remain in the network. Maria stated that physician services do not and have not for along time required prior authorization. Linda asked if that was true last year. Maria stated yes and that it has been true for several years.

Diane Dwyer asked what United Health's recommendation relative to accessing Urgent Care verses emergency room. Maria asked if she meant on the medical side and stated that on the behavioral health side you don't see much of that, but in general on the behavioral side, they prefer to guide members to "crisis appointments and urgent appointments" with providers, agencies, programs, etc. offering the initial evaluation rather than going to an emergency room. From a payment perspective it is acceptable if someone goes to an emergency room.

Richard Leclerc asked Maria to talk about the Child and Family Intensive Treatment Program that they provide as a benefit to most subscribers. Maria stated that United has the CFIT Program similar to Blue Cross. It is available to commercial fully-insured members. This is an important note because unless a self-funded group wants that benefit, it does not automatically apply. It is ten-weeks long with a minimum of six hours per week of intensive treatment that United covers through contracts with the mental health centers, mostly Family Services. George McCahey asked what they used as a clinical entry tool. Maria stated that there are guidelines in place which are more focused on the general clinical information. Virginia Stack asked if there had been any discussion regarding the families meeting the minimum requirement of six hours per week. Maria stated that the provider groups and agencies were comfortable that it was an adequate minimum requirement.

Richard thanked Maria, Kathy and Jason for their presentation.

FOLLOW UP TO CHILDREN'S BEHAVIORAL HEALTH (CBH) INITIATIVES

Janet Anderson introduced two new staff members of DCYF, Virginia Stack and Frank Pace, who will head DCYF's Positive Educational Partnership (PEP) Initiative. They are full-time employees coming from the community bringing tremendous strength to the initiative having been in the Child Adolescent Social Service Program (CASSP).

Janet announced that George McCahey will be retiring at the end of June. He has been DCYF's representative on the Council; she thanked him for his representation of DCYF over several years. Janet also announced that Jeanne Smith, DCYF's Professional Services Liaison to the hospitals, will be DCYF's formal representative; and Carol Fox, who is a member of DCYF's Care Management Team which is community-based, will be Jeanne's backup.

In follow up to her presentation from the February 14, 2006 Council meeting, Janet distributed materials that were previously distributed at the February meeting and stated that if anyone needed further information about the grant, it is posted on DCYF's website.

In response to what is PEP providing, Janet stated that the Positive Educational Partnership (PEP) which is supported by SAMSHA is a six-year infrastructure intending to weave together the CASP system with the preschool and elementary educational system.

Janet stated that Anthony Antosh of the Sherlock Center will be heading up the roll-out and the process of schools continuing to do the Positive Behavioral Intervention and Support (PBIS) work. Janet also stated that it signifies the linking of those PBIS schools with the CASSP system to develop a design that is better than either one by itself. Service funds are being used in this initiative to focus on wraparound dollars because of previous struggles to get more money into the community and prevention sides for kids. These dollars will add to their ability to do wraparound services. Janet explained that "wraparound" means it is a family-driven or child-driven, individually-based focus. After meeting with the family and determining what the family needs, families are provided with community support services, clinical services as well as formal and informal support services for that family to help the child and family move to the most normal lifestyle they can possibly achieve. The

focus of these service dollars is intended to enhance and broaden the ability and capacity in Rhode Island to do wraparound work.

Because it is a SAMSHA grant, the focus is primarily on the children who have Serious Emotional Diagnosis (SED), but because they are linking with PBIS with its preventative focus initiative, it is their intention to reach a broader base.

Janet stated that across the board training is the second most critical way in which they are using the funds from the grant, and is a total transformation within the children's system. It will be outcome based with measures of fidelity that will be followed throughout the course of the grant.

In response to Representative Long's concerns regarding the State's continuance of the project at the end of the six years which are federal years starting on October 1. Janet stated that it is a cooperative agreement which is the new way initiatives from SAMSHA are conducted. During the first year, 1 million dollars is allocated for planning, and Rhode Island is expected to match that amount by one third. The first three years are one-to-three in terms of match, and in the fourth year it is a one-to-one match, and in the last two years it is a two-to-one match. Therefore, it shifts financial responsibility, creating an opportunity for Rhode Island to get the infusion of money from the beginning to set up an infrastructure and then to gradually look at areas from within the State to bring monies into the project. Janet stated that from a federal level the match is required to be new dollars each year, but those new dollars can be and are dollars that have been for residential and other more restrictive levels of care that can be moved into community-based dollars. Janet stated that the thinking is to redistribute the way they are using the money for the children's system and to utilize all that is available in the system to get the best services and the best support. Frank Pace added that this project is designed to bring all the systems together. Kenneth Swanson added that it is bringing agencies together that had worked cooperatively in the past around particular interests, but because PBIS is a competitive grant that has been started and processed through Rhode Island College, it maximizes service dollars by reallocating resources so that they are pooled and used in a much more real way.

Mitch Henderson asked if the planning and implementation have been considered geographically. Janet stated that because the State of Rhode Island is such a small state it will very much be individually driven. Virginia stated that each region has a CASSP system already in place and those lead individuals, called local coordinating councils, know their area.

Frank Pace stated that there are 46 schools currently involved. There were 16 in the first cohort and 28 in the second cohort which started in May 2006. It has spread across the 39 counties of Rhode Island. He stated that nearly every one has at least one school involved. Frank also stated that there are 2 middle schools, 1 high school and 2 early childhood centers included. The rest are elementary schools.

Richard Leclerc asked how many schools would be involved at the maximum point. Janet stated PBIS wants participation from at least 50 percent of the schools throughout the state. Frank stated that there will be 80 schools involved by the end. Janet stated for PEP the requirement by SAMSHA is that there be 8 schools in the first implementation year, 8 schools in the next implementation year, then 16, then 16 and wherever they are at the end. She stated that they will be following this plan in order to establish the model and to make sure that it is working to create the infrastructure.

Janet stated in response to Representative Long's concerns regarding the link with the Child Opportunity Zones (COZs) that they will be involved. Janet stated that the focus of this initiative is to identify and link up the services and the support that exists or needs to be developed for each child and family; therefore, the services that are already established and have strengths will be utilized.

George McCahey suggested that they talk about PBIS and the philosophical transformation throughout the whole school from the basic level to the principle. Virginia explained that it is a school initiative that comes from within the school which is more of a bottom-to-top approach. Frank stated that PBIS is an evidence-based practice implemented by the Office of Special Education

and is data and outcome oriented for schools that foster commitment from everyone from within the entire school system. He described the PBIS three-tiered approach to prevention and intervention. Tier 1 (80 to 90 percent) is called the primary prevention area. Tier 2 (5-10 percent) are the kids who may have some behavioral problems. DCYF and the State spend the most money on the needs of the kids in the top tier which is Tier 3 (1-5 percent). Each school will receive software, a school-wide information system that tracks all three tiers, to determine where behaviors occur; and then each school team will work the positive interventions in those areas. It is a way of transforming discipline to having an environment of support and positive reinforcement in terms of how behavioral problems are handled in the school. Virginia stated that it is an environmental change as well as a cultural change.

Janet stated that the clinical model development has progressed collectively by the schools, providers, family representatives and youth representatives. Each school will create their own version and guidelines.

Janet introduced John O'Reilly to talk about the Policy Academy work which was initiated almost a year ago in New Mexico entitled *Rhode Island Interagency Partnership for Youth in Transition*. The work at the time was mission oriented and conceptual. Janet reported that the work that has been done since then on site has been to put those concepts into practice. The goals and an agenda have been set for this year, they are reporting to the Children's Cabinet on a quarterly basis, and they are conducting research mapping.

John O'Reilly reported that their first follow-up meeting was convened in December 2005. With the membership of the Transition Council which is a group under the Department of Education, Special Needs formed over ten years ago by legislation combined with other community providers and DCYF staff and staff from other agencies meeting monthly since January of 2006. They hope to make their recommendations to the Children's Cabinet in December of 2006. John stated that the goal is to provide a frame of reference for services to youth ages 14 to 21 who have mental health needs. They will work to ensure that these youth receive the support and services they need to successfully transition to adulthood, including education training, and information and skills to perform and maintain positive social relationships. John reported that there are several committees working on current issues such as mental health needs, and aging-out of foster care for 74 youths over 19 who are in an independent living group. Currently, DCYF has 1,528 youth between 14 and 21 within the system which is 53 percent of the population. Many of the youth are 13 to 15 who have been disconnected from family and there are strong efforts to reconnect when possible. John reported that over the last five years they have been developing an infrastructure to provide more services to maintain youth and families longer and provide services in the community sooner and more successfully, but are still faced with placing some of the youths out-of-state.

John stated that they are at a point now to implement what they have been designing and are ready for promulgation and will be surveying all of their formal agencies to identify where the gaps in services are as well as developing more data. The next step in the process during the next few months will be to convene focus groups along with gathering data and then eventually in November or December make specific recommendations to the Children's Cabinet in terms of which services exist, what services needs to be enhanced, and what services are lacking. At this point they are about half way through the process.

REPORT ON NATIONAL CONFERENCE ON MENTAL HEALTH BLOCK GRANT

Richard Leclerc reported that he and George McCahey and Corinna Roy attended a three-day meeting in Washington, D.C. regarding the block grant dovetailed with a Federal Information System conference and the states' Mental Health Planning Councils' meeting.

Corinna Roy reported that the federal government is moving towards a web-based system for submitting the block grant application. She stated that it will allow for greater organization in the format that they are requesting and will hopefully make the review process go smoother.

Corinna reported that there are three areas where they may have to submit some transformation data. Although it is not required at this point, if it is not implemented for September 1, 2006, it may be a requirement in December or at a later date creating a need to revise what had already been done. Therefore, Corinna plans to submit the transformation information that has been asked for ahead of time to avoid those circumstances. Corinna stated that it would entail identifying an outcome measure that is transformative, and currently there are several things that are already being done that are transformative.

Finally, Corinna reported that the Council members and the public in general would be able to review the on-line application making it easier for public comment. Richard added that the due date for the block grant is always September 1 which makes it difficult to review and approve during the month of August. Therefore, it will be submitted with the Council's letter of support to the Governor to be approved retrospectively.

George added that the web-based application is useful and will be helpful to the federal government because they have to collate so much data from throughout the United States and will help the states down the road with measuring trends and what is effective and what may not be.

George stated his concerns regarding the Budget Reduction Act and Medicaid.

George thanked Corinna for her professional assistance with the block grant and her personal communication over the years.

Richard Leclerc stated that Congress had not yet acted on the block grant allocation and there are a number of groups advocating that the whole transformation project be funded separately and not require states to take those funds out of their block grant allocation in order to be able to fund transformation activities. In Rhode Island the amount of dollars from the block grant is about 1.4 or 1.5 million dollars and a good 40 to 50 percent of that would have to be allocated towards transformation activities. Richard stated that the good news is that a lot of what is done now can be classified as transformation activities and clearly meet the federal definition. Therefore, there would be no need to shift gears or move block grant dollars that now go for services into transformation-type planning activities.

Richard stated that SAMSHA is issuing an RFP now taking hold in several states with a few initiatives which came out of the Deficit Reduction Act that was passed last year. One is for states to identify those individuals that have been institutionalized and put a plan together to deinstitutionalize them and they will get a 50 percent increase in the Federal Medical share of the dollars which is good for one year. Richard added that there were a number of trainings and public seminars providing opportunities for training in workforce development.

UPDATES FROM MHRH

Charles Williams stated that Dr. Ellen Nelson, Director of MHRH, has been confirmed. She will be doing a system-wide review across MHRH looking at the department's work, how it is performed and its direction.

Charles stated that as previously mentioned the Mental Health Block Grant due on September 1 is an MHRH focus and work has begun on the Substance Abuse Prevention and Treatment Block Grant which is due to SAMSHA on October 1.

Charles reported that former Acting Director Spangler has left the department and Trisha Leddy from the Department of Human Services will be taking the position of Executive Assistant Director in the MHRH Director's Office who will be focusing on policy and other issues.

OLD/NEW BUSINESS

Charles Williams stated that the Council has confirmed that it wanted to begin the process of developing a Behavioral Healthcare Strategic Plan. Part of that effort included a Letter of Intent requesting funding to the Rhode Island Foundation. Charles reported that in addition to that they have begun to develop a task and timeline for the plan and in order to get the process started have started work on the plan which can be done without any funding from the Foundation.

Charles introduced Kristen Quinlan who is the lead on this project. Kristen distributed a *Task List/Timeline for Strategic Plan (See Attachment I)*. Kristen reviewed the Task List and welcomed questions.

Richard Leclerc asked if the Behavioral Healthcare plan is considering looking at including children and not solely limiting it to adults.

Charles Williams stated that it is a unified behavioral healthcare services plan and mental health and substance abuse will be broken out only to the extent where their specialties are needed. It will focus on interventions from prevention through maintenance, after care, and recovery, and it will cover the lifespan from birth through death. Charles stated that he will be contacting Patricia Martinez some time this week to let her know of our intentions and to begin to find out whom at DCYF would be the best spokesperson to have contact with as they move forward. Charles stated that it is a data-driven, lifespan, continuum of care plan.

Richard stated that although there may be some funds at the national level and the National Association of State Mental Health Planning Councils, he thinks we will need our own resources.

Jill Beckwith of Rhode Island Kids Count distributed copies of their latest *Issue Brief* on building better lives for youth leaving foster care which is not attached. It is available on their website which is www.rikidscount.org.

ADJOURNMENT AND NEXT MEETING

There was no further business. Upon motion made and seconded, the meeting adjourned at 2:45 p.m. The next meeting of the Council is scheduled for **Thursday, July 13, at 8:30 a.m. in the first floor Conference Room 126 at the Barry Hall Building.**

Minutes respectfully recorded and written by:

Mary Ann Nassa
Secretary, Governor's Council on Behavioral Health

Attachment I: Task List/Timeline for Strategic Plan