Indiana Behavioral Health Commission

Meeting Minutes for May 13, 2024
The Children's Museum of Indianapolis
3000 N Meridian St, Indianapolis, Indiana
Chairperson: Jay Chaudhary

A copy of the agenda is posted to
https://www.in.gov/fssa/dmha/indiana-behavioral-health-commission/

Meeting may be viewed at:
https://www.youtube.com/@FSSAIndianavideos

Minutes

Commission Members Present:
Jay Chaudhary
Michelle Clarke
Senator Michael Crider
Zoe Frantz
Steve McCaffrey
Representative Victoria Garcia-Wilburn
Senator Andrea Hunley
Representative Cindy Ledbetter
David Reed
Kellie Streeter
Jason Tomsci
Rachel Yoder

Item 1: Welcome and Approval of Minutes from the April 10, 2024 Meeting

- Jay Chaudhary welcomed everyone to the meeting. He moved the motion to adopt the minutes of the previous meeting. The April meeting minutes were adopted with no changes and with full approval from the voting Commission Members.
- Jay reminded the group that this is the last population-focused meeting for the year and that the goal of the meeting is to provide an overview of the current state of Children's Mental Health. He challenged the group to think boldly about interventions to address Children's Mental Health.

Item 2: Improving Access to Mental Health Services by Supporting Frontline Healthcare Professionals – Presented by Zachary Adams, PhD, HSPP, Co-Director of the Indiana Be Happy Program

- Overview of pediatric mental health
    - Three years ago, the American Academy of Pediatrics and other professional bodies issued a joint statement describing pediatric mental health as a public health emergency.

    - Dr. Adams provided a snapshot of the current state by using several key Indiana survey results showing the high prevalence of emotional, behavioral, or developmental conditions, increasing rates of substance use and deaths due to overdose, and growing rates of suicidal ideation, especially among adolescents that identify as Gay, Lesbian, or Bisexual.
- Summary of gaps in behavioral health supports
    - As many as 2/3 of youth who meet the criteria for need never receive effective care. This is partially attributed to workforce shortages across the state -- pediatricians are often the sole provider of behavioral health services; However, 2/3 of pediatricians say that they do not feel fully resourced or supported to care for their patients experiencing behavioral health challenges.
- Overview of access programs and the Indiana Be Happy Program
    - Child Psychiatry Access Programs (CPAPs), also known as Pediatric Mental Healthcare Access Programs (PMHCAs), are a national framework that provide Primary Care Physicians (PCPs) with a number they can call to speak to a child psychiatrist about what their patient might need. Indiana's Be Happy program is based on this national framework and provides provider-to-provider consultation and a referral support network.
    - Be Happy has had close to 3,000 consultation calls and helped 937 providers. In over half of cases, the child stays with the PCP and recommendations include adjustment to medication or connection to other resources.
- Sustainability Recommendations
    - Be Happy plans to expand to launch an adult program to address the needs of the perinatal population. Currently, Be Happy is funded by grant and contract dollars (state, federal pass-through grants, and philanthropy), but the current Health Resources and Services Administration grant expires in 2026.
    - Sustainable funding will be required to help continue this program to make this service available to PCPs in the long term. The most straightforward solution is to include funding in the next biennium's budget.
    - Additional emerging sustainability best practices include insurance carriers covering a proportional share of program costs and having boards representing state entities and health insurance entities manage the program.

Item 3: Overview of Multisystemic Therapy – Presented by Amanda Broderick, PhD, HSPP, Clinical Director of the Riley Program and Assistant Professor of Clinical Psychiatry

- Overview of Multisystemic Therapy (MST)
    - The goal of MST is to reduce or prevent involvement in the juvenile justice system. MST is an intensive, short-term intervention that provides individually tailored support using small treatment teams to target youth between ages 12-17 who are at risk for serious system consequences, including juvenile justice (probation), Department of Child Services (DCS) involvement, or school expulsion. Outcomes can be tracked within 3-5 months.
- Current state of MST programs in Indiana
    - The Division of Mental Health and Addiction's (DMHA) goal is for all youth to be able to access MST within 60 minutes of their house. DMHA is currently

subcontracted with 12 agencies, providing them with two years of financial support to implement MST services.
    - MST has had positive outcomes relating to youth living at home, remaining in school or working, or avoiding juvenile arrests for both juvenile-justice-system-involved and non-juvenile-justice-system-involved youth.
- MST funding
    - The two main sources for MST reimbursement are the Family Preservation Services contract and Medicaid/private insurance/grant funding.
        - However, these sources are limited as the Family Preservation Services funding only covers youth involved in the DCS system and only 27% of services billed to Medicaid-related plans were reimbursed, and one-time federal grants end in 2025.
- Sustainability Recommendations
    - Dr. Broderick recommended an enhanced Medicaid reimbursement rate, including an MST-specific rate and extending access to those already in Medicaid. The average across all states is $40 per 15 minutes, while the current IN rate is about $21 per 15 minutes.

Item 4: Youth and Social Media – Presented by Bob Wood and LaDonna Hughes, parents from St. Richard's School

- Parent introductions and summary of parent organizing efforts at St. Richard's
    - LaDonna Hughes and Bob Wood, two parents from St. Richard's School, shared about their experiences with their children's social media and electronic device usage and parent organizing efforts. A small cohort of about 32 families collectively decided to try having no phones for their children until high school, to help remove the fear of missing out.
- Commission Discussion
    - Commission Members raised questions about pushback to these efforts and on the level of involvement of the children in this process.
        - Bob described that most understood the logic. Some pushed back desiring to stay in touch with students, while others have found other successful ways of staying in touch. Some parents have stayed neutral and not engaged with the initiative.
        - LaDonna shared that students have been involved in conversations around these efforts focused on holistic development, education, and minimizing social pressures.
    - Jay acknowledged that empowering and educating parents is the lowest burden approach, rather than pursuing a system-wide approach.
    - The presenters recommended the book The Anxious Generation by Jonathan Haidt.

Item 5: High Acuity Youth Continuum Mapping – Presented by Kim Estep (Director for Systems Design and Implementation Strategies at the Innovations Institute at the University of Connecticut), Denise Sulzbach (Former Prosecutor and Professor at the Child Advocacy Center), and Tony Bonadio (Research Professor at the University of Connecticut)

- Jay introduced the presentation by emphasizing the importance of approaching this work from the entire children's care system continuum perspective, not just individual involvement.
- Overview of high acuity youth continuum mapping
    - Kim summarized the current gaps and goals of the system, noting that current pathways to receiving care are often non-linear. She emphasized the goal of providing timely and appropriate support to families with children with high acuity needs.
    - Bridging the gap between the current and desired experience of families should focus on care pathways and be guided by implementation science.
- Challenges to implementing needed changes and addressing individual and diverse needs
    - Implementation is challenged by silos, new initiatives and mandates, the lack of a clear path, and the lack of authority to operationalize strategies.
    - Lack of ownership can complicate determining how to resolve the needs of a child. Oftentimes no single agency is the owner and youth are receiving services across several agencies.
    - There is a need to work together to leverage related platforms, coordinate across agencies, improve data sharing, and work towards common goals. Each part of the system contributes to the broader bucket of services or supports to families.
- Benefits of a comprehensive service array
    - A comprehensive service array focus is family-centered where families are the primary caregivers, which can help prevent caregiver burnout and ensure equity regardless of socio-economic status.
- Commission Discussion
    - Jay summarized the main themes for the group:
        - The whole system matters.
        - Families experience the system in unique ways, but there are common factors and experiences for families (region, equity, etc.).
        - Opportunities exist to create connections across the system and ensure families have access to services to allow for more individualized, family-centered care.
        - It is not as simple as a matter of "we need this much money in these places and that will be good".
        - Kim added that Mobile Crisis Response Stabilization Services (MRSS), including Mobile Crisis Teams (MCTs) and Crisis Receiving and Stabilization Services (CRSS), are main interrupters in the system.
    - Jay noted that DMHA is working with the University of Connecticut team to apply the concepts from this presentation to map the Indiana continuum of care for the Commission.
    - Denise clarified that Day Treatment programs would fall on the intensive side of the continuum in response to a question from a Commission Member.

Item 6: Children's Behavioral Health and the Funding Gap – Presented by Rachael Fisher and David Burton from Riley Children's Health (Riley Children's)

- Overview of children's behavioral health and Riley Children's strategic plan
    - Rachael highlighted the root of the children's behavioral health crisis stems from inadequate funding leading to a workforce shortage and quality and access issues across the continuum.
    - Riley Children's shared an example journey to illustrate the tragic implications of missed early interventions due to inadequate support and screening for behavioral health challenges for a mother and child.
    - Sustainable reimbursement models for mental health services are needed to ensure access to the right care at the right time and help prevent journeys like this.
- Overall challenges in access to care
    - High caseloads and limited access to care are prevalent, leading to the Emergency Department as a backstop intervention for youth in crisis, particularly in rural areas.
    - Community providers may provide services out of their scope as they have limited to no training.
    - Payer type and insurance can significantly impact access to care.
- Evidence-based practices
    - There is considerable evidence that MST and DBT (Dialectical Behavior Therapy) reduce the cost of mental health treatment. Some studies show a 47% cost reduction and up to $20,000 in savings per person. These practices help move a reactive mental health system to a proactive one. However, one barrier to implementing these practices is paying for training.
- Challenges in reimbursement
    - Low reimbursement rates for behavioral health services pose a significant challenge to covering the costs.
    - IU Health experiences a -103% margin on combined facility and professional services for behavioral health; "For every dollar we get, we spend $2".
- Sustainability Recommendations
    - Develop an equitable approach to reimbursement that is comparable to peers in the medical workforce to allow payers to promote meaningful financial incentives and remove administrative burdens.
    - Create reimbursement models that recognize quality care and treatment and enhance rates for providers trained in evidence-based practices, as they ultimately save money due to diversion from more intensive treatments.
    - Provide incentives such as scholarships and loan forgiveness to attract and retain behavioral health providers to create a diverse and representative workforce.
- Commission Discussion
    - Commission Members discussed sustainable funding and legislative actions, including looking beyond the general fund budget and considering options such as a cigarette tax.
        - Sen. Crider emphasized that sustainable resources would impact behavioral health services and adequate funding is needed to attract workforce.

        - David Burton noted that Riley is in communication with employers as well, who want to enhance behavioral health options for their employees.
    - Commission Members drew attention to the need for parity between behavioral and physical health reimbursement approaches.
        - Steve McCaffrey noted that when Indiana passed the Parity Act, it was focused on persons receiving services, but did not focus on provider reimbursement.
    - Regarding demonstrating savings from MST, Rep. Cindy Ledbetter asked if costs would significantly multiply if a person enters residential care, particularly for acute cases.
        - Rachael and David clarified that costs of services are not necessarily linear: more acute needs do not necessarily mean more costs.
        - Zoe Frantz noted that the administrative costs for behavioral health should be reflected in the rates.
    - Sen. Crider thanked the team at Riley for pushing this system forward.
        - David Burton noted many smaller or less resourced hospitals face closures due to challenges in funding; whereas larger providers, such as Riley, may be able to cover more cost differentials.

Item 7: Pediatrician Perspective on Complex and Severe Mental Health Illness – Presented by Dr. Rachel Woods from Columbus Pediatrics

- Trends in children's mental health
    - Trends in 2022 through 2024 show the older the child, the higher the percentage in diagnosis for depression, ADHD, or anxiety.
    - During COVID-19, Columbus Pediatrics received more calls for acute behavioral health issues despite seeing fewer patients.
- Example case
    - Dr. Woods shared a case study from a patient at Columbus Pediatrics to demonstrate the needs and experiences of her patients. This case study followed a young child who was involved with DCS from 2014-2022 and was placed in foster care, experienced abuse, experienced behavioral health challenges, and was admitted to both short- and long-term care facilities. The patient had various specialist and therapist consults including Riley Developmental Pediatrics, Adult and Child, Centerstone, Riley Psychiatry, and Be Happy and was prescribed several medications.
    - This case highlighted how treating children who have experienced trauma with medication is often unsuccessful.
- Challenges in treating intergenerational trauma and relying on out-of-home care
    - Dr. Woods shared that there is no easy fix for a child who has experienced trauma. It is often difficult to have conversations with families who may be the root cause or a significant factor in the child's trauma.
    - Long-term stays can also have limited impacts as they do not address triggers in the home or from family in real time.
- Commission Discussion

- Commission Members commented on caseload and trauma-informed care training.
    - Dr. Woods highlighted the challenge of managing large caseloads, with each doctor in her practice overseeing around 1,400 patients. These observations come from the types of patients she sees.
- The Commission suggested looking into Project Echo.

Item 8: Department of Child Services Perspective on Children's Mental Health – Presented by David Reed, Deputy Director of Child Welfare Services at the Department of Child Services (DCS)

- Overview
    - David Reed summarized the decreasing trends in the number of DCS youth in residential treatment over time, emphasizing the importance of keeping kids with families whenever possible.
- Children's Mental Health Initiative (CMHI) overview
    - CMHI serves severely mentally ill youth without Medicaid or eligibility for DMHA's services. Currently, 921 youth are in the program, with approximately 1/3 adopted from foster care. 24 CMHI youth are in residential stabilization programs.
    - Many kids are waiting for care, including DCS kids waiting for hospital admission or gatekeeper approval for admission and DCS youth over 18 in residential waiting for a Bureau of Disabilities Services (BDS) adult beds.
- Efforts to keep kids with families
    - The Intensive Foster Care program aims to place youth with kinship or relative care families. DCS has released a procurement (RFP) to ensure a provider is in each county and pay caregivers the maximum per diem ($76/day) to keep youth out of facilities.
    - The hope is to have a contract in place in each county by fall of 2024.
- Recommendations
    - Collaboration between DCS, BDS, and DMHA to build a better safety net that provides mental health care for youth proactively rather than through DCS.
    - Work with providers on reimbursement structures and other barriers to more intensive outpatient services.
    - Explore opportunities to diversify services available in CMHI/Child Mental Health Wraparound (CMHW).
    - Work with DOE to ensure that youth can stay in school.
    - Review acute hospital admission criteria and length of treatment to address the issue of provider engagement with DCS referrals and increase family engagement.
    - Review Psychiatric Residential Treatment Facility (PRTF) programs and contracting to improve access and clarify how to fund indigent/uninsured.
    - Review state hospital admission processes and treatment approaches. Ensure that no youth is "too" acute.
- Commission Discussion
    - Commission Members raised questions about training and incentivizing training for families

        - David explained the ideal would be bringing an expert to meet a child where they are to provide support and help caregivers understand best practices (e.g., shower routines, homework routines, bedtime routines).
        - Challenges related to background checks for relatives and the need for training stipends are noted.
    - Kellie Streeter noted that training is the biggest issue in her county. She has seen an exploding number of youth detention cases and noted the judicial system impact in this.

Item 9: Frameworks for Comprehensive School Mental Health Support – Presented by Michelle Clark, Director of Student, School, and Family Engagement at the Department of Education (DOE)

- Overview of trends
    - About 1/3 Hoosier high school students reported their mental health as not good and 31.6 per 10,000 ages 10-17 were hospitalized for major depressive disorders.
    - More students need intensive interventions than schools have the time or resources to support.
- Summary of comprehensive school mental health approach
    - Carrying the Torch, Indiana's model for comprehensive school counseling, provides opportunities to be data-driven and ensure positive outcomes for all.
    - The value of comprehensive school mental health includes better academic outcomes, access to care, early identification and intervention, positive school climate and safety, youth, family, educator, and peer engagement, continuum of services, and better psychosocial outcomes.

Item 10: Comprehensive School Mental Health Framework – Presented by Dr. Brandie Oliver, Butler University

- Overview of Comprehensive School Mental Health (CSMH) Framework
    - Dr. Oliver worked collaboratively with IDOE to develop a detailed framework that outlines how schools can use this Comprehensive School Mental Health (CSMH) Framework.
    - The CSMH Framework is a comprehensive approach integrated within the Multi-Tiered Systems of Support (MTSS) aimed to provide a continuum of social, emotional, behavioral, and mental health supports and services to support students, families, educators, and all stakeholders within the school community.
    - The CSMH is comprised of 6 core components:
        - School climate and culture, emphasizing safety for students and teachers
        - Mental health and wellbeing
        - Social and emotional development, addressing stigma and social media influence
        - Positive discipline
        - School safety, covering climate and culture, suicide, school shootings, and violence
        - Educator and student wellness, considering holistically wellbeing
    - The implementation process involves setting the stage and building awareness, exploring data and building capacity, preparing through planning and identifying

funding, initial implementation by engaging key partners, and continual implementation and monitoring.

- CSMH framework Request For Proposals (RFP)
    - Dr. Oliver summarized the College of Education at Butler University CSMH Framework RFP, which offers up to $200,000 to support 3-4 schools in implementing the framework.
- Commission Discussion
    - It was acknowledged that while schools are vital access points, not everyone supports the CSMH framework.
    - Concerns were raised about replicating successful models, such as Hope Academy for Students with Substance Use Disorder, and ensuring sustainable funding.
    - Rachel Fisher clarified the distinction between wraparound services and MST.
        - MST is an evidence-based practice that provides an intensive level of care. Not every CMHW provider is also providing MST.
    - Jay emphasized the need to justify funding requests and include estimates and predictions based on data where possible (e.g., MST data). Commission Members discussed incorporating Wellbeing Informed by Science & Evidence (WISE) and CMHI program data into final report recommendations.

Item 11: Closing Remarks

- Jay thanked all of the presenters and Commission Members for their time and encouraged the Commission to start wide and focus on developing recommendations that can meaningfully move the needle while navigating challenging restrictions in the behavioral healthcare continuum.