## Indiana Behavioral Health Commission

Meeting Minutes for December 2, 2020, 1:00 pm - 3:00 pm

Livestreamed at: https://www.in.gov/fssa/dmha/indianabehavioral-health-commission/

Chairperson: Jay Chaudhary

# Minutes

### Commission Members Present:

| | | | |
|---|---|---|---|
| Katy Adams | Christy Berger | Sharon Bowman | Matt Brooks |
| Carrie Cadwell | Jay Chaudhary | Donna Culley | Scott Fadness |
| Mimi Gardner | Rachel Halleck | Timothy Kelly | Brooke Lawson |
| Ray Lay | Chase Lyday | Anthony Maze | Stephen McCaffrey |
| Leah McGrath | Christine Negendank | Mike Nielsen | Katrina Norris |
| Jim Nossett | Barbara Scott | Allison Taylor | Rep. Cindy Ziemke |
| Senator J. D. Ford | Senator John Ruckelshaus | | |

### Commission Members Absent:

Rep. Melanie Wright

### Guests Present:

Suzanne Crouch, Lieutenant Governor
John Roeder, Special Assistant to the Lieutenant Governor

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

The commission members were notified the live recording and livestreaming for the public was in progress.

### The following items were discussed:

### Item 1: Commission Member Roll Call
### *and introductions from members who were unable to share at previous meeting.

#### Outcome:

- Special guest Lieutenant Governor Suzanne Crouth and Special Assistant John Roeder present

- Members unable to share their interest in serving on the Commission during the previous meeting provided their view, including Carrie Cadwell, Stephen McCaffrey, Jim Nossett, Anthony Maze.

### Item 2: Overview of the Meeting Topics

#### Outcome:

- J. Chaudhary outlined two streams of focus for the Commission: addressing SMI and the overall well-being of Hoosiers; the intertwining of these areas of focus. J. Chaudhary introduced this overall discussion beginning with an overview of the continuum of care in Indiana.

## Item 3: Continuum of Care in Indiana Presentation by Lindsey O'Neal and Erin Quiring

### Outcome:

- The presentation provided an overview of federal and state legislation, providers and services that comprise the public mental health system
  - B. Scott recommended a deeper analysis on CMHCs - the nature of the populations they serve, volume of individuals served, and changes over those characteristics over time
  - C. Lyday asked whether there are any mandates for CMHCs in regard to care provision.
    - Response: CMHCs must have a crisis response mechanism, but this is variable.
  - C. Cadwell emphasized the variability of the presentation of the crisis response mandate, advocated mapping out the steps of a crisis response, as well as focusing on an expansion in this area for Indiana.

## Item 4: Review of October 9, 2020 Minutes

### Outcome:

- The Commission voted on the minutes
  - M. Brooks moved to approve the minutes, seconded by R. Lay, none opposed, there were no abstentions, the minutes were approved.

## Item 5: Commission Member Survey Results by Kelsi Linville, Alexis Pless, and Amy Brinkley

### Outcome:

- The survey results reviewed the legislation defining the Commission, the purpose of the survey, and key takeaways from the survey outcomes.
  - M. Brooks recommended adding commercial insurance to the considerations of funding sources.
  - On discussion of barriers, M. Brooks advocated removal of term "monopolization" and recommended a discussion of Medicaid as a tool for vulnerable population groups.
  - S. McCaffrey explored whether there were significantly different findings between the commission member survey and the Indiana Recovery Council (IRC) consumer survey.
    - Response: the survey findings were mostly congruent; funding was more of a focus from commission members than for consumers.
  - R. Halleck confirmed congruency, emphasized differences appear to be regional in regards to timely access; advocated a strategy to resolve is enacting objective measurement of access statewide.

*Please find a copy of the presentation and the corresponding survey analysis summary on https://www.in.gov/fssa/dmha/indiana-behavioral-health-commission/.

## Item 6: Wishlist/Magic Wand Discussion by Rachel Halleck

### Outcome:

- The Commission discussed a review of progress in the past ten years of the mental health landscape, as well as dream strategies to implement if funding were not an issue in the areas of clinical supervision, training, documentation, data collection, and self-managing quality assurance.
  - See the discussion outcomes in Addendum A.
  - R. Halleck notified the Commission there would be a continuation of this discussion via survey that will explore the road to 100%, what is missing/lacking, and what contributes to disparities.

## Item 7: Future Meetings

### Outcome:

•A Doodle Poll will be used to determine the next meeting date.

### Follow-up Action Items:

- Respond to Doodle Poll for next meeting arrangements.
- Review the analysis of outcomes of the IRC and Commission Member surveys.
- Complete the upcoming continuum of care survey.

### Comments from the public:

1. "This was mentioned in the slide and then its meaning questioned by Matt B. It might be referencing the monopoly that the CMHCs have on the Medicaid Rehabilitation Option (MRO). There are perfectly qualified -- and Medicaid certified -- providers who aren't CMHCs who by statute are not allowed to provide MRO services; they can provide Medicaid Clinic Option, by not MRO. This creates unnecessary service bottlenecks at the CMHCs."
2. "Do not forget the needs of the incarcerated mental health people. They need to receive and make sure they do take medications."

Addendum A

# Continuum of Care Magic Wand Discussion

## Discussion Framework:

- Transparency
- Objective, solution-focused approach
- A commitment that the landscape *can* improve
- Group dedication to a vision of improved care across the state

**Q1: In the past decade, there have been many improvements in the MH/SUD treatment landscape; What sorts of improvements have you seen?**

| Commission Member | Area of Improvement | Recommendation |
|---|---|---|
| C. Cadwell | Integrated care | MH care does not need to be time sensitive, model access like other care practices. |
| D. Culley | Family-focused care, trauma-informed care, Wraparound, families having voice/choice. | |
| K. Norris | Addiction care, MAT, addressing stigma in SUD area. | Increase relevancy for and appreciation of all members of inter-disciplinary teams. |
| C. Lyday | 1. Focus on prevention, use of educating on the social-emotional connection of behavior as a prevention strategy.<br>2. Use of mental health units with police has been successful and showed improvements. | |
| C. Berger | There has been an increase in partnership between schools and mental health providers; a holistic approach. | |
| T. Kelly | There has been an increase in SUD residential providers, recovery coaches, MAT, motivational interviewing. | 1. Improve strategies of engagement with the goal of transitioning with consumers through various levels of care.<br>2. Address the limited resource pool of recovery housing, increase access in the level of care under inpatient care; avoid providing care in unrealistic environments.<br>3. Avoid reimbursement for dangerous treatment approaches. |
| B. Lawson | Suicide prevention work has improved, training of teachers. | 1. Increase evidence-based tools to respond to SI.<br>2. Increase supports for post inpatient treatment.<br>3. Foster partnerships between schools and mental health providers to continue holistic approach. |

| | | |
|---|---|---|
| M. Gardner | 1. Integrated care - FQHC approach is working (seamless physical health and mental health care), also reduces stigma.<br>2. Trauma-informed training at all levels of staffing. | Continue integrated care approach; focus on benefits of interdisciplinary teams. |
| R. Lay | 1. Introduction of dual diagnosis treatment.<br>2. Integration of peer supported recovery. | |
| S. Bowman | 1. Increased cooperation across the state to improve access to inpatient/residential care.<br>2. Telehealth. | |

**Q2: If you had all the funding you needed, how would our treatment framework look different in the following areas: clinical supervision, staff training, documentation, data collection, internal quality assurance?**

| Commission Member | Recommendation | Advocacy/ "The Why" |
|---|---|---|
| S. Bowman | Increase sites and funding for students to access, reimburse trainers. | |
| K. Norris | Pursue specialty in forensics. | |
| B. Scott | Increase time for work by reducing administrative burdens on CMHCs. | Loss of staff after long periods of onboarding and supervision for credentialling. |
| A. Maze | 1. Ensure training is consistent across environments.<br>2. Address barrier of not being able to view documentation across environments. | 1. Loss of continuity when transitioning environments. |
| K. Adams | 1. Train/education workers to respond to any set of needs.<br>2. Develop a competency rating/checklist<br>3. Streamline documentation across systems | 1. There is a need to acknowledging people as complex individuals.<br>2. N/A<br>3. Streamlined documentation would allow for an increase in data collection. |
| C. Cadwell | Establish practiced-based evidence; monitor for outcomes, measure performance. | We won't know where to train if we don't know where we're not effective, supports assessing for the appropriate duration of treatment, prevents burnout. |
| R. Halleck | Using client feedback to inform outcomes to support burden on clinician documentation. | |
| C. Negendank | Improve communication across systems so all parties are knowledgeable of each others' work, as well as when a consumer moves through system points. | |

**Closure to discussion:**

- S. Fadness posed question regarding status of the state's infrastructure to inform on current resources available.
    - Response: This is an upcoming anticipated discussion at a future meeting.