



STATE OF TENNESSEE
COUNCIL ON CHILDREN'S MENTAL HEALTH

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Council on Children's Mental Health
December 10, 2009
10:00 a.m. – 3:00 p.m.
Otter Creek Church of Christ, Brentwood, TN

MEETING SUMMARY

Attendee List:

| | | |
|---------------------|-------------------|--------------------|
| Susan Adams | Karen Franklin | Freida Outlaw |
| Sandra Allen | Karen Gibbs | Becky Owen |
| Sumita Banerjee | Nneka Gordon | Steve Petty |
| Louise Barnes | Sharon Green | Elizabeth Reeve |
| Olivia Bedne | Cheri Hoffman | Kathy Rogers |
| Bonnie Beneke | Jennifer Houston | Mary Rolando |
| Shawn Brooks | Bill Huskey | Ajanta Roy |
| Pam Brown | E. Ann Ingram | John Rust |
| Edwina Chappell | Sheila Keith | Mary Linden Salter |
| Michelle Covington | Dustin Keller | Sara Smith |
| Stephanie Dickerson | Richard Kennedy | Steve Sparks |
| Sita Diehl | Rachel Krauss | Debrah Stafford |
| Katrina Donaldson | Ray Lyons | Millie Sweeney |
| Bob Duncan | Kim Crane Mallory | Pat Wade |
| Richard Edgar | Emma Martin | Ronald Wigley |
| Emel Eff | Michael Myszka | Ellyn Wilbur |
| Emily Einstein | Allen Nope | Lygia Williams |
| Richard Epstein | Linda O'Neal | |

Welcome and Introductions

- ***Linda O'Neal, Tennessee Commission on Children and Youth (TCCY)***
 - Provided an update on the CCMH meeting space and change to February meeting date.
 - Commissioner Virginia Trotter Betts is unable to attend today's meeting. Dr. Freida Outlaw, Assistant Commissioner will provide an overview of the Department of Mental Health and Developmental Disabilities' (TDMHDD) recent budget presentation to the Governor.

➤ **Dr. Freida Outlaw, TDMHDD**

Departmental Budget Presentation to the Governor – November 23, 2009

- The Commissioner presented a total budget including the Governor's request of nine percent cuts – six percent first tier, three percent second tier. Because the Children and Youth Services Division took many cuts last year, the largest children's cut for this year will be the elimination of the 14 children and youth inpatient beds at Middle Tennessee Mental Health Institute (MTMHI) for a cost savings of \$1 Million. We believe we have enough resources in the private sector to handle the need for children and youth inpatient beds. This is consistent with our belief in building a system of care as we want to keep children out of the most restrictive environments.
- We just completed two Federal site visits for our JustCare Family Network grant in Memphis. A two-day visit was for the National Evaluation Technical Assistance site visit and the second four-day visit was for the development of the Single Coordinated Technical Assistance Plan (SCTAP).
- Outlaw provided a review of the K-Town Youth Empowerment Network grant initiative in Knoxville. Work is beginning and the funding will not be stalled in the legislative process this year.
- TDMHDD just submitted a new grant proposal for the Early Connections Network, a System of Care in the Mid-Cumberland Region focused on the 0-5 population, with a special focus on military families. Our previous system of care sites have not focused on early childhood. By focusing on this population, it would allow us to strengthen the continuum. We did receive technical assistance from national experts as well as our project officer, which helped us make the decision not to submit a statewide System of Care proposal. We will hear about the award the last week of September 2010. *Refer to handout "Abstract" provided at meeting.*
- The RIP program (Regional Intervention Program) is NOT moving to the Easter Seal building in case you have seen reports in the media.

Linda O'Neal

- I encourage you to view the budget hearings for the child serving departments. It was apparent the Commissioners proposed options, not recommendations. If these options were to be included by the Governor in his proposed budget, we will lose the last quarter century of progress, especially in the area of children's mental health.
- Please remember Connie Givens' family members and their loss.
- Acceptance of the October 8, 2009 Meeting Summary is postponed until the next CCMH meeting on February 25, 2010.

➤ **Sara Smith, Director of Coordinated School Health and Nicole Cobb, Director of Counseling Department of Education (DOE)**

Discussion of the Tennessee Schools and Mental Health Systems Integration Grant

- *Refer to the PowerPoint "Tennessee Schools and Mental Health Systems Integration Grant Update" and the handout "Tennessee Board of Education Mental Health Standards & Guidelines" provided at the meeting.*

- The Department of Education received a Tennessee Schools and Mental Health Systems Integration Grant. The partners were the Office of School Coordinated Health, DOE Director of Counseling and Vanderbilt University.
- The purpose is for the promotion of statewide mental health guidelines to more actively address mental health needs. Regional trainings provided for participants to draft an action plan, and 716 people participated in the regional trainings.
- We received overwhelming support and appreciation from Local Education Agencies (LEA) fostering state level support to accomplish goals.
- Vanderbilt staff will be providing technical assistance to address barriers.
- The grant will focus on policy and infrastructure changes, specifically to develop Memoranda of Understandings (MOU) with community-based mental health providers, and to develop mental health teams within each LEA.
- The goal is to promote coordination of care and alignment of resources in each community.
- The “other side of the report card” (social and emotional health) is just as important as the academic issues.
- Schools can put into place for free new state mental health guidelines to build capacity without stretching the budget.

Nicole Cobb encouraged CCMH members to read the guidelines

- Step 1 – State board had to pass the guidelines, which they did in July 2009. Renee Love at Vanderbilt coordinated 14 trainings across the state. All but six LEAs attended the training. Renee said most representatives included school counselors, etc.
- DOE staff hope LEAs connect the dots with existing Systems of Care.
- Question: How is “family-driven” being envisioned with this?
- Answer: Families have told us when they are seeking support and referrals outside the school system, they are not getting them. We are not at the point of being able to refer parents to other parents for support.
- Question: How are families being educated about mental health parity or available insurance support for the services they need?
- Answer: We are currently not training on payment systems, but would welcome it.
- A list of LEA team leaders will be circulated through Dustin.

➤ ***E. Ann Ingram, Dr. Cheri Hoffman, Kathy Rogers – Mule Town Family Network Presentation***

- *Refer to handout provided at meeting “Outcomes of MTFN” and “MTFN Report Card” for information presented.*

➤ ***Millie Sweeney, Tennessee Voices for Children (TVC) – National Federation of Families for Children’s Mental Health Meeting***

- The Federation just launched a national initiative to promote Evidence-Based Practices through credentialing Family Support Providers (FSP) and getting FSPs as a Medicaid reimbursable service. TVC will be sitting on the advisory committee.
- TVC received a national award – Carl Dennis Unconditional Caring Award, based on our work with FSPs and our Systems of Care like Mule Town, JustCare, and K-Town, and hopefully Early Connections.

➤ ***Bob Duncan, Director and Stephanie Dickerson, Assistant Director for CoverKids – Presentation about CoverKids***

- It was a difficult decision to suspend enrollment. CoverKids started in 2007 after the Governor’s personal efforts to obtain an S-CHIP program (State – Children’s Health Insurance Program). We anticipated we would be covering 40,000 to 45,000 children. We are currently covering 44,000 children. We have suspended enrollment because we do not have the appropriated dollars to cover more children.
- We have suspended medical, dental, and vision benefits for working families who cannot afford private insurance. Those who are currently covered will continue to be covered.
- Mental health parity is a part of the new S-CHIP program. If there are no benefit limits on health services, there can be no limits on behavioral health services. This includes inpatient and outpatient services. We implemented parity in April 2009 even though it was not required until October 2009.

➤ ***Steering Committee Meeting Summary***

- Refer to handout “December 4, 2009 Steering Committee Meeting Summary” provided at meeting.
- Workgroups need to be more focused and have specific tasks, which are outlined on the handouts included in packets. When meeting over lunch, Workgroups were to think about scheduling a meeting prior to the next meeting in February 2010.
- Workgroups were asked to review the handouts and provide responses to be presented about their discussion in response to the questions after lunch.

➤ ***Break for lunch at 11:30am. Workgroups meet over lunch. Report out at 1:30pm***

➤ ***Workgroup Presentations on Six Questions:***

Refer to the following handouts provided at meeting:

- “Workgroup Lunch Meeting Outline and Tasks”
- “CCMH Workgroup Structure and Next Steps”
- Two-Sided graphic depiction of proposed statewide System of Care Structure
 - Model A: Funding arrow points to the circle labeled “System Administrator.”
 - Model B: Funding arrows point to the circles labeled “System Administrator, System of Care, and Traditional.”

Question 1: What are the questions or considerations that should be answered about the system structures options presented at the October meeting as they relate to your Workgroup? Please identify the preferred structure and the reasons for the preference.

Workgroup Responses:

1. Service Array – Did not pick one. The group discussed the CANS and getting funding for non-medically necessary services.
2. Cultural and Linguistic Competence (CLC) – Favored a single System Administrator – A.

3. Accountability/Management Information Systems (MIS) – Favored multiple funding streams – B. How do we ensure system drives policy change using system-wide data? B model provides the opportunity to access data universally, but business as usual can continue. There are obstacles in order to do this; it will require data sharing agreements and cost sharing, which may mean money will be diverted from services.
4. Funding – Preferred B model. Recognized existing system is currently in place for providers is working. Recognizes at community level there are multiple agencies already receiving money creating a system. Funding can be sent to multiple areas. Our group broke the System Administrator in half to include both local and state System Administrator. Complex cases could be handled at the state level. Local level can handle traditional care. This model balances the risk for high end users. Local planning and development of a service plan for children, access to statewide funds for complex care (i.e., psychiatric hospitals).
5. Interagency Collaboration – Not sure how either model would be operationalized, and it was unclear how agencies fit it. Where do the dollars come from? Is it just for case coordination, a better description of agencies' roles is needed. Idea to take test cases and walk them through the model to ascertain how it is operationalized and where funding comes from, how much and for what kind of services.
6. Family Engagement – As a family, if we are in need we want services as quickly as possible. We discussed whether it would delay it more to have a system administrator. We preferred Model B because it would not delay accessibility to services.
7. Evidence-Based Practices (EBP) – We discussed a standardized screening tool to inform EBPs. Information we garner through the screening process, we can identify where evidence-based practices need to be shored up and generate the most robust array of services available to families.

Question 2: Who/What should be the oversight entity for the system of care and why? For example, if the CCMH were to be the collaborative group to provide oversight for the statewide System of Care, who would have administrative control of the CCMH and the Administrative Entity?

Workgroup Responses:

1. EBP – Not sure what the oversight entity should be with regard to EBP.
2. Interagency Collaboration: 3 potential options 1) TCCY - any entity would need to have teeth via legislated authority because non-governmental organization (NGO) authority would be questioned; 2) GOCCC – relationship; or 3) CCMH – acknowledge benefits of having all stakeholders together, would best serve as advisory board to whatever oversight entity was decided.
3. MIS – Oversight entity needs to have clout, be comprised of agency heads, Managed Care Organization (MCO) representatives, and consumers. Decision making authority would rest with the funders.
4. CLC – CCMH is recommended.

5. Service Array: Needed more information before deciding. Thought oversight needed to come from multiple agency representatives. Suggested using MuleTown Family Network as a model site to test an administrative oversight entity because it is fully functional now.
6. Funding – Thought oversight entity should be CCMH. Administrator should be a separate entity or a single access point for state services. Administrative authority should rest with TCCY.
7. Family Engagement – Oversight entity needed to have experience in system of care and what needs to be done. TDMHDD as the oversight entity is preferred. Administrative authority should be a team of multiple disciplines with family input. Not only a single person or single field making a decision, but one with true family focus being understood. Thought the Centers of Excellence (COEs) with some family focus might work.

Question 3: What are your thoughts about who the administrative entity should be, i.e. the decision makers who authorize services?

Workgroup Responses:

1. CLC – Administrator should be advocacy group and have regional Community Service Agencies act as regional administrators.
2. EBP – Administrator (virtual term) eligibility should be local, monitoring auditing functions at local/regional level using existing collaborative groups rather than creating a new entity that might not withstand budget cuts.
3. MIS – Accountability for authorization of services should occur at local level, but have one platform for care coordination.
4. Interagency Collaboration – Cannot determine until we know exactly how the System of Care model will work
5. Service Array – Needed more information before deciding. Thought entity should not be tied to one specific field.
6. Funding – State level administrator should be an independent Administrative Service Organization (ASO), a brand new agency. Care management could occur at the regional level and local administrators could be existing agencies.
7. Family Engagement – See Question 2.

Question 4: What is the target population to be served under the system of care from the perspective of the Workgroup?

Workgroup Responses:

1. Interagency – 0-24 all systems.
2. Funding – Ditto, all systems all kids.
3. CLC – Thought all children at first, then 10-18 unless there was an identified need at the school level.
4. Service Array – All children, but pilot with Department of Children’s Services (DCS) custody children who receive TDMHDD funding to experiment with multiple funding services.

5. Family Engagement – 0-21 with multiagency involvement.
6. MIS- Needed to be specific criteria identified for kids to enter into the SOC Multiple Agency system services.
7. EBP – Identify multisystem children with emotional needs.

Question 5: What screening instrument or other mechanism should be used to trigger entry to system of care services?

Workgroup Responses:

1. EBP – CANS
2. MIS – CANS
3. CLC – CANS leading to additional assessments
4. Interagency – CANS
5. Service Array – CANS
6. Funding – CANS if it is the most cost effective and appropriate instrument. We questioned the implementation of the CANS, not the instrument itself.
7. Family Engagement – CANS

Question 6: From the perspective of the Workgroup, what criteria should be used to identify pilot sites and/or future sites for proposals for federal funding for system of care sites?

- *Linda O'Neal prefaced the workgroup reports on this question by describing the issues with budget cuts and we will most likely have to suggest using the three existing SOC sites as pilot sites. We need to be prepared as we move forward to mobilize.*

Workgroup Responses:

1. MIS – Did not get to this question.
2. Funding – Did not answer.
3. CLC – Consider rural and urban areas.
4. Service Array – We did not define a specific process but determined there would need to be a process defined, perhaps the existence of groups or stakeholders who were willing to participate.
5. Family Engagement – Existing sites, but future sites should be based on needs within the community.
6. Interagency Collaboration – Discussed how to go about identifying community readiness using existing tools. In future when we do have some funds for statewide implementation, will experience rapid ramping up. Entertain intentionality of preparing for System of Care elements while awaiting funding and support local System of Care efforts.
7. EBP – Build upon current sites. Future sites based on service utilization data and assessing local interest and support to build upon, use planning council process to identify areas of need, don't overlook occurring planning resources.

General Discussion on Workgroup Reports:

- Dustin Keller – It was evident this would be a good opportunity to discuss what other sites do that works.
- Freida Outlaw – Intentionality is important. JustCare and K-Town were funded because they were built upon the work groups were doing at the local level. I think it's a good idea to build upon when you go back to your communities.
- Traci Sampson – There is work to be done with local groups for receptivity. Adopt System of Care values and principles, which takes years and years to understand and implement. I thought it was interesting the MIS group was the only group limiting oversight and policy decisions to funders. We structure the system in this way because it is the only way we felt change could occur. We have to make sure we have institutional change so those who come after adhere to what we decide. We understand this is a hard conversation to have. That's why we said CCMH could be an advisory group, but the authority needed to lie with the funders.

Other Discussion:

- Next Meeting Topics:
 - Dr. Jeanne James will discuss TennCare HEDIS data;
 - Child Protective Services (CPS) – Select Committee on Children and Youth presentation on their study of CPS as well as SOC involvement in the multiple response system;
 - Judge Sharon Green and Kathy Benedetto will discuss the current collaboration taking place in Northeast; and
 - Workgroups will meet and report at next meeting.
- The Steering Committee will meet in late January; workgroups were asked to meet before then.
- Mary Rolando suggested targeted questions should be provided to workgroups to advance their work.
- Workgroups need to provide critical questions to CCMH for planning and implementation purposes.
- February 25th meeting will again be at Otter Creek Church of Christ.