Commonwealth of Massachusetts

Executive Office of Health and Human Services

THE CHILDREN'S BEHAVIORAL HEALTH ADVISORY COUNCIL

Annual Report

October 2009

The Commonwealth of Massachusetts
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October 1, 2009

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I am pleased to transmit the first annual report of the Children's Behavioral Health Advisory Council (Council), established under the provisions of Chapter 321 of the Acts of 2008, which was signed into law on August 20, 2008.

As the report indicates, the members have been duly appointed, and the Council has organized itself into subject matter committees designed to ensure compliance with the legislative mandates, as well as the formulation of recommended policies that will address the behavioral health needs of all the children of the Commonwealth.

Much of the work over the past months has been devoted to developing the organizational framework to create a robust and vibrant Council. As a result, the Council is not at this time recommending any specific legislative or regulatory change, nor does it have policy recommendations. It does, however, want to use this annual report to brief policy makers and others on its activities, the work of its immediate predecessor – the Children's Behavioral Health Initiative Advisory Group – and to share with policy makers and others its vision and expectations going forward.

As Commissioner of the Department of Mental Health and *ex-officio* Chair of the Council, I am grateful for the time, energy and commitment Council members have extended. I look forward to the next twelve months as the Council, the Administration, the Legislature and others work to develop a comprehensive, integrated community-based system of care – one that is accessible and responsive to families and their children with behavioral, emotional and mental health needs, and provides them the services they need to succeed at home, at school and in the community.

Sincerely,

Barbara A. Leadholm, M.S., M.B.A.
Chair, Children's Behavioral Health Advisory Council

PART I: INTRODUCTION & OVERVIEW

Section 1 of Chapter 321 of the Acts of 2008 established the Children's Behavioral Health Advisory Council (Council) and placed the Council, "within but not subject to control of, the executive office of health and human services. Additionally, the language of the specific section states the Council is to, "advise the governor, the general court and the secretary of health and human services." (**Appendix A**)

We start our first annual report with the above quotes because we think it vital to our mission, and ultimately to the families and children of the Commonwealth, that everyone understand that the Council was established as an independent advisor to both the Executive and Legislative branches. Our credibility as an advisory body depends upon our independence and ongoing commitment to advocate for policies, practices, procedures, and, when necessary, legislation that best serve the families and children of the Commonwealth with emotional disorders and behavioral health needs. Our policy recommendations should not depend upon who is governor, who is the Executive Office of Health and Human Services (EOHHS) Secretary or which political party represents the majority in the Legislature. Our recommendations should be guided by our expertise, experience, and our commitment to the families and children of the Commonwealth. To do anything less would be a disservice to both branches, as well as to those children and families.

Obviously, economic and other factors cannot be ignored in the creation of or advising on policy. Council members, diverse as they are, live and work in the "real world" and all of us understand the imperfections and limitations of all human enterprises, whether public or private. But we also know that the legislation that spawned this Council resulted in large part from poor access to mental health care and services, as well as late identification and treatment of children with known treatable disorders; complex and fragmented "non-systems" of care for children, adolescents and their families; overcrowded emergency rooms boarding children in need of inpatient beds; children stuck in costly inpatient units for weeks awaiting decisions about more appropriate, community-based care; and the lack of school and community-based services. At the same the children's mental health bill was moving through the legislative process, a comprehensive and significant decision by the federal court in the case of *Rosie D v. Romney* was issued. The decision was a watershed action and became the catalyst for Chapter 321 of the Acts of 2008. We believe Chapter 321 demonstrated the legislative and executive branches recognition that it was time for bold vision and systemic change.

To be sure, before the legislation creating the Council was signed, efforts were underway to reform and transform the system. Before reviewing the Council's activities over the past several months, it is appropriate to review two important factors that contributed to a much needed and critical focus on the children's mental health system in the Commonwealth.

(A) Rosie D. v. Romney

In 2002, a class action lawsuit, *Rosie D. v. Romney*, was filed in the federal court on behalf of children with serious psychiatric disorders. In January 2006, the Court ruled the Commonwealth was in violation of the federal Medicaid law by failing to provide home-based services to an estimated 15,000 children with serious emotional disturbance. The Commonwealth was found to be lacking in the provision of services specifically required by Medicaid – early and periodic screening, diagnostic and treatment services (EPSDT).

To its credit, the Patrick Administration decided not to appeal the decision, thereby delaying change for years. Instead, it set about the task of fashioning a remediation plan to comply with the Court's decision. In February 2007, the Court approved a modified version of the Commonwealth's plan, and incorporated it into a final judgment with strict timetables. A court monitor was appointed to oversee the implementation of the remedy.

The implementation of the Court's order in the *Rosie D* case has changed and is still changing the landscape for mental health service delivery for children and adolescents in Massachusetts.

Mental health screening by primary care clinicians began in November 30, 2007. Use of the Massachusetts CANS (Child and Adolescent Needs and Strengths), a standardized decision support tool used as part of the assessment process, began November 30, 2008. The Department of Mental Health (DMH) began using the Massachusetts CANS as part of its eligibility determination process and for periodic reviews of clients receiving case management services. This marks the first time that the Department of Social Services (now Department of Children and Families) DMH and Medicaid providers will be using essentially the same measuring instrument.

In Spring 2009, the Massachusetts Behavioral Health Partnership (MBHP) in conjunction with the MassHealth managed care entities, selected provider agencies to serve as Community Service Agencies (CSAs) providing Intensive Care Coordination (ICC) and Family Support, based on the wraparound model ordered in the case. These services began June 30, 2009.

There is a CSA for each of the 29 geographic areas of the Department of Children and Families (DCF) as well as three CSAs, not limited to a single DCF area, that were chosen for their expertise in serving specific linguistic and cultural communities (African-American, Latino, Deaf and Hard of Hearing).

Additional new Medicaid services are being phased in, with In-Home Behavioral Services and Therapeutic Mentoring beginning October 1, 2009, In-Home Therapy starting November 1, 2009 and Crisis Stabilization starting December 1, 2009.[1]

[1] The Commonwealth is obligated to implement the new remedy services if the federal Medicaid agency, the Centers for Medicare and Medicaid Services (CMS), approves the services as Medicaid services. Six of

(B) Children's Behavioral Health Initiative

The Children's Behavioral Health Initiative (CBHI) is an interagency initiative of the Commonwealth's Executive Office of Health and Human Services. Its stated mission is to strengthen, expand and integrate Massachusetts state services into a comprehensive, community-based system of care, to ensure that families and their children with significant behavioral, emotional and mental health needs obtain the services necessary for success in home, school and community.

While the Court's order in the *Rosie D* case is limited to children enrolled in MassHealth (the Commonwealth's managed Medicaid Program), implementation of the remedy is viewed as the first phase of the broader Children's Behavioral Health Initiative (CBHI).

DMH and the other state child-serving agencies in EOHHS have each written agency-specific protocols defining their interface with the CSA's. The DMH protocol intends to assure that eligible Medicaid enrollees are aware of and have access to Intensive Care Coordination (ICC), Family Partners, and Mobile Crisis Intervention services to ensure continuity of care if youth lose their Medicaid entitlement, and to facilitate access to DMH services for youth enrolled in ICC who need them.

As the *Rosie D* remedy is implemented, DMH and the other agencies will continue to review their current services and delivery systems with a view to minimizing duplication and fragmentation of services.

PART 2: ACTIVITIES OF THE COUNCIL

(A) Strategic Plan

As required by the law, the appointed members of the Council were duly nominated and appointed to terms ranging from one to three years. An orientation program was available to those who had not been aware of the activities of the activities of the CBHI Advisory Group. A listing of the Council Members is attached as **Appendix B**.

The first meeting of the Council occurred on December 1, 2008, at which time the Council reviewed a strategic plan, which had been developed during the tenure of the CBHI Advisory Group, and which had been approved by EOHHS. We have included this strategic plan (**Attachment C**) because: (1) many of the original CBHI Advisory Group are now members of the Council; (2) we believe it represents the kind of ambitious planning and priority establishment that needs to occur; and (3) while not yet formally adopted by the Council, it could serve as a potential and important blueprint for the months and years ahead.

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the seven remedy services have been approved by CMS, while discussions are ongoing between the Commonwealth and CMS regarding Crisis Stabilization.

(B) Organizational Activities

At its March 23, 2009 meeting, the Council decided to establish standing committees. After discussion of appropriate subject areas, the Council appointed from among its members a working group to suggest how the Council should initially organize itself and conduct business.

On April 27, 2009, the Council accepted the report of its working group and established the following standing committee and work group:

Standing Committees

1. Culturally Informed, Best and Promising Practices
How do we strengthen clinical practice in Massachusetts? What practices have been shown to work through research and evidence in other parts of the country or world? How do we ensure that practice is culturally-informed? How might "evidence-based" or "evidence-informed" practices be culturally adapted for different populations? How do we learn from best and promising practices that have NOT been researched?

2. Legislative and Regulatory
(includes licensing standards, culturally-informed regulations)

3. Child Systems Integration
(includes courts, juvenile justice, child welfare, substance abuse, interagency issues, intellectual disabilities, racial and ethnic disproportionality and disparities)

4. Insurance
(includes insurance, client continuity, system fragility and the business of developing a robust community-based service system)

5, Healthcare Disparities Reduction and Elimination
(includes comprehensive approach to disparities reduction and liaisons to other committees on culturally-informed practice)

6. Data, Trends and Outcomes (Behavioral Health Research and Training Center working group has been merged with this Committee)
Provides guidance on the future Behavioral Health Research and Training Center, review and analyze data and reports as described in Ch 321 and summarize findings to Advisory Council,, monitor CBHI data, including disparities, training, and outcomes data, inform work of other committees)

Work Group (*time limited)*

Workforce Development

With respect to the standing committees, the Council also decided:

- They should be reviewed annually to make certain they are reflective and responsive to the statutory requirements of the Council and its work.
- Committees should make concerted efforts to include individuals not on the Council, so long as the chair(s) are members of the Council.
- Committees and work groups should be racially and ethnically diverse, and attentive to strategies for reducing behavioral health disparities as part of their recommendations.
- Family members and youth should be actively sought to serve on every Committee and work group. Family Partners might serve as a resource for the family member role.
- When better economic times emerge, the Commonwealth should compensate the transportation costs for family members and youth, and EOHHS should have a dedicated person to provide support to family members and youth serving on the Council and its committees and work groups.
- Committees should prepare written reports to the Council.

The standing committees and work groups have been meeting and have determined priorities and action plans.[2] A listserv has been established to provide quick communication between and among the committee co-chairs.

The Council has received previous reports on various aspects of the children's mental health system, including the Final Report of the Governor's Commission on Children's Mental Health (July 1, 2005), the Final Report of the Commission on the Status of Mental Health Services for Children (December 1998), An Implementation Report on the Recommendations of the Gaebler Commission May 2001). Moreover, we have reviewed more current data on children awaiting placements in the community.

(C) Report of the Clinical Working Group

For the same reasons we included the strategic plan, we have attached as **Appendix D** the CBHI's Clinical Working Group's Final Report & Recommendations. This Report, which has been presented to the Council, is scheduled for further review and comment at a Council meeting later this year. Nevertheless, it is included because of the quality of its recommendations and the fact it will be an important guide and resource to the Council as it enters the first full year of its existence.

CONCLUSION

The Council has attempted to organize and position itself to meet all of its responsibilities. Moreover, we have sought to create a structure flexible enough to adapt, when necessary, but with the strength and stability to create a blueprint that goes beyond current or immediate issues, as well as our economic downturn.

[2] Attached collectively as Appendix E to this Report are copies of Action Plans developed by Council Committees and the Workforce Development Group.

While our tasks are enormous, the resources limited, and timeframes short, our vision – consistent with the provisions and intent of Chapter 321 - remains broader than the court order and forward thinking. Immediate issues may at times govern the priorities of the Council and its committees, but we are committed to looking to the future and developing an advisory body that is credible, reliable, and independent.

We are grateful for the assistance and support we have received from the Department of Mental Health Commissioner Barbara Leadholm, EOHHS Secretary JudyAnn Bigby, M.D. and the wonderful people at DMH, EOHHS and the child serving agencies within EOHHS. Special thanks to Joan Mikula, Lester Blumberg, Stephen Cidlevich from DMH, Emily Sherwood and Jackie Gelb (EOHHS) and Suzanne Fields (MassHealth) for their professionalism, patience and graciousness in helping the Council get organized and for all they do for the people of the Commonwealth.

LIST OF APPENDICES

Appendix A **Chapter 321 of the Acts of 2008**

Appendix B **Listing of Council Members**

Appendix C **Strategic Plan**

Appendix D **Report of CBHI Clinical Working Group**

Appendix E **Committee and Work Group Action Plans**

- **Culturally Informed, Best and Promising Practices Committee**
- **Legislative and Regulatory Committee**
- **Child Systems Integration Committee**
- **Insurance Committee**
- **Healthcare Disparities Reduction and Elimination Committee**
- **Data, Trends and Outcomes Committee**
- **Workforce Development Work Group**

Appendix A

Chapter 321 of the Acts of 2008

AN ACT RELATIVE TO CHILDREN'S MENTAL HEALTH.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same as follows:

SECTION 1. Chapter 6A of the General Laws is hereby amended by inserting after section 16*O* the following 4 sections:-

Section 16P. The secretary of health and human services shall facilitate the coordination of services for children awaiting clinically-appropriate behavioral health services by convening a monthly meeting of agencies within the executive office of health and human services, the department of early education and care, and the department of elementary and secondary education.

The secretary shall publish a monthly report on the status of children awaiting clinically-appropriate behavioral health services. The report shall include, but need not be limited to, the following data for the previous month: (i) the number of children who are MassHealth members who are awaiting psychiatric hospitalization in hospital emergency rooms or at emergency services sites after an exhaustive search has failed to identify an available bed in a psychiatric hospital and the average length of time each such child shall be required to wait before such a bed is identified; the number of such children in psychiatric hospitals awaiting post-hospitalization residential placement or community-based services, including their agency affiliation, if any; the number of such children temporarily placed and awaiting appropriate longer-term placement; (ii) an estimate of the numbers of available psychiatric hospital beds, residential school placements approved under chapter 71B, group homes by agency, and foster home placements, and how long those beds were available; and (iii) the data reported by the department of children and families under section 23 of chapter 18B and the department of mental health under section 24 of chapter 19.

The monthly report shall be submitted to the children's behavioral health advisory council, the child advocate and the general court by filing it with the clerks of the senate and the house of representatives, the joint committee on mental health and substance abuse, the joint committee on children, families and persons with disabilities, and the senate and house committees on ways and means.

Section 16Q. (a) There shall be a children's behavioral health advisory council within, but not subject to control of, the executive office of health and human services. The council shall advise the governor, the general court and the secretary of health and human services.

(b) The council shall consist of not fewer than 24 members and shall be comprised of: (i) the following 10 members, who shall serve ex officio: the commissioner of mental health, who shall serve as chair, the commissioner of children and families, the commissioner of youth services, the commissioner of mental retardation, the commissioner of public health, the commissioner of elementary and secondary education, the commissioner of early education and care, the commissioner of insurance, the director of Medicaid, and the child advocate, or their designees; (ii) additional persons appointed by the secretary of health and human services from the aforementioned agencies and from the executive

office of health and human services; and (iii) 1 person from each of the following organizations appointed by the secretary of health and human services from a list of nominees submitted by each organizations:- Parent/Professional Advocacy League, Inc.; Massachusetts Psychological Association, Inc.; Massachusetts Association of Behavioral Health Systems, Inc.; Massachusetts Psychiatric Society, Inc.; Children's League of Massachusetts, Inc.; the Massachusetts chapter of the American Academy of Pediatrics; New England Council of Child and Adolescent Psychiatry, Inc.; Mental Health and Substance Abuse Corporations of Massachusetts, Inc.; the Massachusetts chapter of the National Association of Social Workers; Massachusetts Hospital Association, Inc., Blue Cross and Blue Shield of Massachusetts, Inc., Massachusetts Association for Mental Health, Inc., Massachusetts Behavioral Health Partnership, Massachusetts Society for the Prevention of Cruelty to Children, and Massachusetts Association of Health Plans, Inc.; and (iv) the following 4 community and provider members appointed by the secretary of health and human services: 2 persons under the age of 22 who are consumers of behavioral health services; a physician, pediatrician or child and adolescent psychiatrist from a community health center; and a professional with expertise in human services workforce development. The members of the children's behavioral health advisory council shall represent the culturally and linguistically diverse populations served by the executive office and its agencies.

The terms for nongovernmental members shall be 3 years. Upon the expiration of his term, a nongovernmental member shall serve until a successor has been appointed; provided, however, that if a vacancy exists prior to the expiration of a term, another nongovernmental member shall be appointed to complete the unexpired term.

(c) The council shall review: (i) the reports on the status of children awaiting clinically-appropriate behavioral health services provided by the secretary of health and human services under section 16P; (ii) the behavioral health indicators reports provided by the department of early education and care under subsection (g) of section 3 of chapter 15D; (iii) the research reports provided by the children's behavioral health research center under section 23 of chapter 19; and (iv) legislative proposals and statutory and regulatory policies impacting children's behavioral health services.

(d) The council shall make legislative and regulatory recommendations related to: (i) best and promising practices for behavioral health care of children and their families, including practices that promote wellness and the prevention of behavioral health problems and that support the development of evidence-based interventions with children and their parents; (ii) implementation of interagency children's behavioral health initiatives with the goal of promoting a comprehensive, coordinated, high-quality, safe, effective, timely, efficient, equitable, family-centered, culturally-competent and a linguistically and clinically appropriate continuum of behavioral health services for children; (iii) the extent to which children with behavioral health needs are involved with the juvenile justice and child welfare systems; (iv) licensing standards relevant to the provision of behavioral health services for programs serving children, including those licensed by entities outside of the executive office of health and human services; (v) continuity of care for children and families across payers, including private insurance; and (vi) racial and ethnic disparities in the provision of behavioral health care to children.

(e) The council shall submit an annual report, with legislative and regulatory recommendations, by October 1st to the governor, the secretary of health and human services, the commissioner of early education and care, the commissioner of elementary

and secondary education, the child advocate and the general court, by filing them with the clerks of the senate and the house of representatives, the joint committee on mental health and substance abuse, the joint committee on children, families and persons with disabilities, the joint committee on health care financing and the senate and the house committees on ways and means.

(f) The meetings of the council shall comply with chapter 30A, except that the council, through its by-laws, may provide for executive sessions of the council. No action of the council shall be taken in an executive session.

(g) The members of the council shall not receive a salary or per diem allowance for serving as members of the council, but shall be reimbursed for actual and necessary expenses reasonably incurred in the performance of their duties.

Section 16R. There shall be geographically-based interagency review teams to collaborate on complex cases when a child, which shall include a person under the age of 22 who is disabled or has special needs, may qualify for services from multiple state agencies consisting, as determined by the needs of the individual child, of representatives selected from agencies within the executive office of health and human services, the department of early education and care, and the department of elementary and secondary education. If appropriate and if proper consent has been provided, representatives of local education agencies and juvenile probation shall be invited to participate. Such a child may be referred to the team by a state agency, the juvenile court or the child's parent or guardian. The teams, after hearing from the parents or guardian of the child, relevant agencies and service providers, and reviewing relevant materials, shall determine which services, including case management services, are appropriate for the child and who shall provide those services. If the team is unable to reach a consensus decision, the matter shall be referred to the regional directors of the respective agencies for resolution. The regional directors shall meet within 10 business days of the referral and shall issue their decision within 3 business days thereafter. If the regional directors are unable to resolve the case and the disagreement involves matters solely within the purview of the executive office of health and human services, the team shall notify the secretary of health and human services who shall render a decision within 30 days of the notice.

If the parent or guardian of the child disputes the decision of the team or the secretary, the parent or guardian may file an appeal with the division of administrative law appeals, established under section 4H of chapter 7, which shall conduct an adjudicatory proceeding and order any necessary relief consistent with state or federal law.

Nothing in this section shall be construed to entitle a child to services to which the child would be otherwise ineligible under applicable agency statutes or regulations.

Notwithstanding chapters 66A, 112 and 119 or any other law related to the confidentiality of personal data, the teams, the secretary and the division of administrative law appeals shall have access to and may discuss materials related to the case while the case is under review once the parent or guardian has consented in writing and those having access agree in writing to keep the materials confidential. Once the review is complete, all materials shall be returned to the originating source.

The secretary of health and human services, the commissioner of elementary and secondary education and the commissioner of early education and care shall jointly promulgate regulations to effectuate the purposes of this section.

The secretary of health and human services shall publish an annual report by February 15 summarizing the cases reviewed by the teams in the previous year, the length of time

spent at each stage and their final resolution. The report shall be provided to the child advocate.

Nothing in this section shall limit the rights of parents or children under chapter 71B, the federal Individuals with Disabilities Education Act, 20 U.S.C. 1400 et seq., or Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. 794 et seq.

Section 16S. The secretary of health and human services shall coordinate the purchase of behavioral health services for children to promote economy and efficiency and improve service delivery, thereby integrating services provided by the executive office of health and human services into a comprehensive, community-based behavioral health delivery system. The secretary shall establish guidelines for the department of children and families, the department of youth services, the department of public health, the department of mental retardation and the office of Medicaid for the delivery of behavioral health services to children, including children subject to proceedings under sections 39E to 39J, inclusive, of chapter 119, pursuant to which the commissioner of mental health shall be consulted in the design and implementation of the commonwealth's behavioral health services for children; and the secretary shall consult with the commissioner of early education and care and the commissioner of elementary and secondary education to establish similar guidelines for those respective departments.

SECTION 2. The second paragraph of section 2 of chapter 15D of the General Laws, inserted by section 24 of chapter 215 of the acts of 2008, is hereby further amended by adding the following clause:-

(t) subject to appropriation, provide consultation services and workforce development to meet the behavioral health needs of children in early education and care programs, giving preference to those services designed to prevent expulsions and suspensions.

SECTION 3. Section 3 of said chapter 15D, as appearing in section 32 of said chapter 215, is hereby amended by striking out subsection (g) and inserting in place thereof the following subsection:-

(g) The board shall submit an annual report to the secretary of education, the secretary of administration and finance, and the clerks of the house of representatives and senate, who shall forward the same to the joint committee on education, describing its progress in achieving the goals and implementing the programs authorized in this chapter. The report shall evaluate the progress made toward universal early education and care for preschool-aged children and toward reducing expulsion rates through developmentally appropriate prevention and intervention services.

The department shall include an annual report on behavioral health indicators that includes estimates of the annual rates of preschool suspensions and expulsions, the types and prevalence of behavioral health needs of children served by the department, the racial and ethnic background of the children with identified behavioral health needs, the existing capacity to provide behavioral health services, and an analysis of the best intervention and prevention practices, including strategies to improve the delivery of comprehensive services and to improve collaboration between and among early education and care and human services providers. The report and any recommendations for legislative or regulatory changes shall be submitted by February 15th to the secretary of health and human services, the secretary of administration and finance, the children's behavioral health advisory council, the child advocate, and the general court by filing it

with the house committee on ways and means, the senate committee on ways and means, the joint committee on education, the joint committee on mental health and substance abuse, the joint committee on children, families and persons with disabilities, the clerk of the house and the clerk of the senate.

SECTION 4. Section 4 of said chapter 15D, as most recently amended by section 34 of said chapter 215, is hereby further amended by adding the following paragraph:—
The commissioner shall consult with the commissioner of mental health prior to taking an action substantially affecting the design and implementation of behavioral health services for children under guidelines established by the secretary of health and human services and the commissioner of early education and care under section 16S of chapter 6A.

SECTION 5. Section 5 of said chapter 15D, as amended by section 35 of said chapter 215, is hereby further amended by adding the following clause:—
(17) training to identify and address infant toddler and early childhood behavioral health needs.

SECTION 6. Section 1 of chapter 18A of the General Laws, as appearing in the 2006 Official Edition, is hereby amended by adding the following paragraph:—
The commissioner shall consult with the commissioner of mental health prior to taking an action substantially affecting the design and implementation of behavioral health services for children under guidelines established by the secretary of health and human services under section 16S of chapter 6A.

SECTION 7. Section 7 of chapter 18B of the General Laws, as so appearing, is hereby amended by adding the following subsection:—
(m) The commissioner shall consult with the commissioner of mental health prior to taking any action substantially affecting the design and implementation of behavioral health services for children under guidelines established by the secretary of health and human services under section 16S of chapter 6A.

SECTION 8. Said chapter 18B is hereby further amended by adding the following section:—
Section 23. If the department has care and custody of a child receiving inpatient psychiatric services, the department shall contact the child's parents or guardians, as appropriate, and a member of the child's treatment team within 3 business days of the hospitalization, shall maintain weekly contact with them until the child is discharged, and shall immediately begin discharge planning, with the priority of returning the child to his home or to a community placement. Not later than 5 business days after being notified that continued hospitalization is no longer clinically appropriate, the department shall determine the appropriate type of placement for the child and shall immediately initiate the placement referrals. The department shall document its activities in assisting with discharge placement, including identification of available resources for home-based, community or alternative residential placements, and the barriers, if any, to discharge to the most clinically-appropriate setting. If the initial placement shall not be deemed to be the most clinically-appropriate, the department shall continue to seek an appropriate placement. Not longer than 30 days after being notified that continued hospitalization is

no longer clinically appropriate, the department shall refer the child to the interagency review team established pursuant to section 16R of chapter 6A. The department shall submit a monthly report to the secretary of health and human services detailing the activities undertaken pursuant to this section, including the length of time required to place each such child in a clinically appropriate post-discharge setting.

SECTION 9. Chapter 19 of the General Laws is hereby amended by adding the following 3 sections:—

Section 22. The commissioner of mental health shall be consulted on the design and implementation of the commonwealth's behavioral health services for children, under guidelines established by the secretary of health and human services under section 16S of chapter 6A.

Section 23. There shall be, within the department of mental health, a children's behavioral health research center, the primary mission of which shall be to ensure that the workforce of clinicians and direct care staff providing children's behavioral health services are highly skilled and well trained, the services provided to children in the commonwealth are cost-effective and evidence-based, and that the commonwealth continues to develop and evaluate new models of service delivery. Subject to appropriation, the center shall conduct activities as the commissioner may direct in furtherance of its primary mission, which may include: (i) collecting quarterly data from state agencies, the juvenile court, the commissioner of probation, service providers and insurance providers relative to children's behavioral health services; (ii) researching the best practices for the identification and treatment of children's behavioral health needs; (iii) evaluating the demand for and the availability, cost and quality of, children's behavioral health services provided by the commonwealth; (iv) publishing annual progress reports, including the estimated costs and benefits of implementing new programs or practices, the status of racial and ethnic disparities, and the capacity of the behavioral health system to meet clinically appropriate inpatient, residential and community-based service demands; and (v) providing information on a regular basis to the children's behavioral health advisory council, established by section 16Q of chapter 6A.

The center shall publish an annual report including: (i) narrative and statistical information about service demand, delivery and cost, and identified service gaps during the prior year; (ii) the effectiveness of the services delivered during the prior year; and (iii) review of research analyzed or conducted during the prior year. The center shall submit the annual report by February 1st to the governor, the children's behavioral health advisory council, the child advocate and the general court, by filing it with the clerks of the senate and the house of representatives, the joint committee on mental health and substance abuse, the joint committee on children, families and persons with disabilities, the joint committee on health care financing and the senate and the house committees on ways and means.

Section 24. If the department is notified that a child who is eligible for department services is receiving inpatient psychiatric services, the department shall contact the child's parents or guardians and a member of the child's treatment team within 3 business days of being so notified, shall maintain weekly contact with them until the child is discharged, and shall, with the consent of the child's parent or guardian, immediately begin discharge planning, with the priority of returning the child to his home or to a

community placement. Not later than 5 business days after being notified that continued hospitalization is no longer clinically appropriate, the department shall determine the appropriate type of placement for the child and, with the consent of the child's parent or guardian, shall immediately initiate the placement referrals. The department shall document its activities in assisting with discharge placement, including identification of available resources for home-based, community or alternative residential placements, and the barriers, if any, to discharge to the most clinically-appropriate setting. If the initial placement shall not be deemed to be the most clinically appropriate, the department shall continue to seek an appropriate placement. Not longer than 30 days after being notified that continued hospitalization is no longer clinically appropriate, the department shall refer the child to the interagency team established pursuant to section 16R of chapter 6A. The department shall submit a monthly report to the secretary of health and human services detailing the activities undertaken pursuant to this section, including the length of time required to place each such child in a clinically-appropriate, post-discharge setting.

SECTION 10. Section 2 of chapter 19B of the General Laws, as appearing in the 2006 Official Edition, is hereby amended by adding the following paragraph:—
The commissioner shall consult with the commissioner of mental health prior to taking an action substantially affecting the design and implementation of behavioral health services for children under guidelines established by the secretary of health and human services under section 16S of chapter 6A.

SECTION 11. Section 1A of chapter 69 of the General Laws, as so appearing, is hereby amended by adding the following paragraph:—
The commissioner shall consult with the commissioner of mental health prior to taking an action substantially affecting the design and implementation of behavioral health services for children under guidelines established by the commissioner and the secretary of health and human services under section 16S of chapter 6A.

SECTION 12. Section 2 of chapter 111 of the General Laws, as so appearing, is hereby amended by inserting after the third paragraph the following paragraph:—
The commissioner shall consult with the commissioner of mental health prior to taking an action substantially affecting the design and implementation of behavioral health services for children under guidelines established by the secretary of health and human services under section 16S of chapter 6A.

SECTION 13. Section 1 of chapter 176O of the General Laws, as so appearing, is hereby amended by inserting after the definition of "Ambulatory review" the following definition:—
"Behavioral health manager", a company, organized under the laws of the commonwealth or organized under the laws of another state and qualified to do business in the commonwealth, that has entered into a contractual arrangement with a carrier to provide or arrange for the provision of behavioral health services to voluntarily enrolled members of the carrier.

SECTION 14. Subsection (a) of section 7 of said chapter 176O, as so appearing, is hereby amended by adding the following clause:—
(7) a statement: (i) that an insured has the right to request referral assistance from a carrier if the insured or the insured's primary care physician has difficulty identifying medically necessary services within the carrier's network; (ii) that the carrier, upon request by the insured, shall identify and confirm the availability of these services directly; and (iii) that the carrier, if necessary, shall obtain out-of-network services if they are unavailable within the network.

SECTION 15. Said chapter 176*O* is hereby further amended by adding the following 3 sections:—
Section 18. A carrier for whom a behavioral health manager is administering behavioral health services shall be responsible for the behavioral health manager's failure to comply with the requirements of this chapter in the same manner as if the carrier failed to comply.
Section 19. A carrier for whom a behavioral health manager is administering behavioral health services shall state on its new enrollment cards issued in the normal course of business, within one year, the name and telephone number of the behavioral health manager.
Section 20. (a) A behavioral health manager shall provide the following information to at least 1 adult insured in each household covered by their services:
(1) a notice to the insured regarding emergency mental health services that states:
(i) that the insured may obtain emergency mental health services, including the option of calling the local pre-hospital emergency medical service system by dialing the 911 emergency telephone number or its local equivalent, if the insured has an emergency mental health condition that would be judged by a prudent layperson to require pre-hospital emergency services;
(ii) that no insured shall be discouraged from using the local pre-hospital emergency medical service system, the 911 emergency telephone number or its local equivalent;
(iii) that no insured shall be denied coverage for medical and transportation expenses incurred as a result of such emergency mental health condition; and
(iv) if the behavioral health manager requires an insured to contact either the behavioral health manager, carrier or the primary care physician of the insured within 48 hours of receiving emergency services, notification already given to the behavioral health manager, carrier or primary care physician by the attending emergency physician shall satisfy that requirement;
(2) a summary of the process by which clinical guidelines and utilization review criteria are developed for behavioral health services; and
(3) a statement that the office of patient protection, established by section 217 of chapter 111, is available to assist consumers, a description of the grievance and review processes available to consumers under chapter 176*O*, and relevant contact information to access the office and these processes.
(b) The information required by subsection (a) may be contained in the carrier's evidence of coverage and need not be provided in a separate document. Every disclosure described in this section shall contain the effective date, date of issue and, if applicable, expiration date.
(c) A behavioral health manager shall submit material changes to the information

required by subsection (a) to the bureau of managed care, established by section 2 of chapter 176*O*, at least 30 days before their effective dates and to at least 1 adult insured in every household residing in the commonwealth at least biennially.
(d) A behavioral health manager that provides specified services through a workers' compensation preferred provider arrangement that meets the requirements of 211 CMR 112.00 and 452 CMR 6.00 shall be considered to comply with this section.

SECTION 16. Section 77 of chapter 177 of the acts of 2001 is hereby repealed.

SECTION 17. Notwithstanding subsection (b) of section 16Q of chapter 6A of the General Laws, the initial terms of the 14 nongovernmental members appointed under clauses (iii) and (iv) of said subsection (b) of said chapter 6A on the children's behavioral health advisory council, established by said section 16Q of said chapter 6A, shall be designated by the secretary of health and human services as follows: 5 members for terms of 1 year, 5 members for terms of 2 years, and 4 members for terms of 3 years.

SECTION 18. (a) The office of Medicaid shall convene a working group on the early identification of children's developmental, mental health and substance abuse problems in pediatric primary care settings. The working group shall include representatives from the pediatric, mental health, and substance abuse communities, and patient and child advocacy organizations. It shall review the office of Medicaid's current regulations on the early and periodic screening, diagnosis and treatment program, and make recommendations about the periodicity of screenings, the screening tools used, the training and education of those conducting the screenings and treatment protocols. The recommendations shall be submitted by July 31, 2009 to the general court by filing them with the clerks of the senate and house of representatives, the joint committee on mental health and substance abuse and the senate and house committees on ways and means.
(b) Notwithstanding any general or special law to the contrary, by October 31, 2009, the office of Medicaid and the division of health care finance and policy shall develop 1 or more reimbursement rates for use by primary care providers conducting developmental, mental health and substance abuse screenings. The rates shall be reasonably calculated to cover the cost of screening tools and the time to screen, score and interpret the results. Screenings shall be reimbursed separately from the standard office visit case rate for children enrolled in MassHealth. The office of Medicaid shall require a managed care organization providing these screenings to children enrolled in MassHealth to reimburse separately for these screening services.

SECTION 19. (a) There shall be a task force on behavioral health and public schools, within the department of early education and care, to build a framework to promote collaborative services and supportive school environments for children, to develop and pilot an assessment tool based on the framework to measure schools' capacity to address children's behavioral health needs, to make recommendations for using the tool to carry out a statewide assessment of schools' capacity, and to make recommendations for improving the capacity of schools to implement the framework.
(b) The task force, consisting of 10 members who shall serve ex officio and 16 members appointed by the commissioner of elementary and secondary education shall include the commissioner of elementary and secondary education, who shall serve as chairperson, the

commissioner of early education and care, the commissioner of mental health, the commissioner of mental retardation, the commissioner of public health, the commissioner of children and families, the commissioner of transitional assistance, the director of Medicaid the commissioner of youth services, and the child advocate, or their designees; 2 parents of children with behavioral health needs; 1 adult who had behavioral health needs as a child; 4 community-based behavioral health providers, 1 of whom works with schools, 1 of whom works with parents of children with behavioral health needs, 1 of whom has expertise in the behavioral health effects of trauma, and 1 of whom is implementing the remedial plan related to *Rosie D. v. Romney*, 410 F.Supp.2d 18 (CA No. 01-30199-MAP); 1 advocate who represents parents or children in the areas of behavioral health, trauma, and education; 2 school principals; 2 teachers; 2 school psychologists; and 2 school-based student support persons selected from schools participating in the commonwealth's Safe and Supportive Learning Environments grant program established by subsection (b) of section 1N of chapter 69 of the General Laws, the Schools Initiative of the executive office of health and human services, the federal grant program to integrate schools and mental health systems established by 20 U.S.C. § 7269, or similar programs.

(c) The task force shall: (i) build a framework that promotes collaboration between schools and behavioral health services and promotes supportive school environments where children with behavioral health needs can form relationships with adults and peers, regulate their emotions and behaviors, and achieve academic and nonacademic school success and reduces truancy and the numbers of children dropping out of school; (ii) develop a tool based on the framework to assess the capacity of schools to collaborate with behavioral health services and provide supportive school environments that can improve outcome measures such as rates of suspensions, expulsions and other punitive responses, hospitalizations, absenteeism, tardiness, truancy and drop-out rates, time spent on learning and other measures of school success; (iii) pilot the assessment tool in at least 10 schools; (iv) make recommendations for using the tool to carry out a statewide assessment; and (v) make recommendations for improving the capacity of schools to implement the framework.

(d) The framework shall address:

(i) leadership by school administrators to create structures within schools that promote collaboration between schools and behavioral health providers within the scope of confidentiality laws;

(ii) professional development for school personnel and behavioral health service providers that: clarifies roles and promotes collaboration within the scope of confidentiality laws; increases cultural competency; increases school personnel's knowledge of behavioral health symptoms, the impact of these symptoms on behavior and learning, and the availability of community resources; enhances school personnel's skills to help children form meaningful relationships, regulate their emotions, behave appropriately and succeed academically, and to work with parents who may have behavioral health needs; increases providers' skills to identify school problems and to provide consultation, classroom observation and support to school personnel, children and their families; and increases school personnel's and providers' knowledge of the impact of trauma on learning, relationships, physical well being and behavior, and of school-wide and individual approaches that help traumatized children succeed in school;

(iii) access to clinically, linguistically and culturally-appropriate behavioral health

services, including prevention, early intervention, crisis intervention, screening, and treatment, especially for children transitioning to school from other placements, hospitalization, or homelessness, and children requiring behavioral health services pursuant to special education individual education plans;

(iv) effective academic and non-academic activities that build upon students' strengths, promote success in school, maximize time spent in the classroom and minimize suspensions, expulsions, and other removals for students with behavioral health challenges;

(v) policies and protocols for referrals to behavioral health services that minimize time out of class, safe and supportive transitions to school, consultation and support for school staff, confidential communication, appropriate reporting of child abuse and neglect under section 51A of chapter 119 of the General Laws, and discipline that focuses on reducing suspensions and expulsions and that balances accountability with an understanding of the child's behavioral health needs and trauma; and

(vi) policies and protocols for a truancy prevention program certification by the department which may include mechanisms to provide technical assistance to school districts and to encourage each school district to adopt and implement a truancy prevention program which meets the certification criteria.

(e) The commissioner of elementary and secondary education shall convene the task force on or before December 31, 2008.

(f) The task force shall submit an interim report to the governor, the child advocate and to the general court by filing the report with the clerks of the senate and the house of representatives, the joint committee on mental health and substance abuse, the joint committed on children, families and persons with disabilities, and the joint committee on education, on or before December 31, 2009. The interim report shall: (i) describe the framework; (ii) explain the assessment tool and the results of its pilot use; and (iii) propose methods of using the tool to assess statewide capacity of schools to promote collaborative services and supportive school environments.

(g) The task force shall submit a final report to the governor, the child advocate, and to the general court by filing the report with the clerks of the senate and the house of representatives, the joint committee on mental health and substance abuse, the joint committee on children, families and persons with disabilities, and the joint committee on education on or before June 30, 2011. The final report shall: (i) detail the findings of the statewide assessment; and (ii) recommend a plan for statewide utilization of the framework.

SECTION 20. The MassHealth behavioral health contractor, in collaboration with the department of mental health and the department of elementary and secondary education, shall develop a proposal for the provision of behavioral health consultative services to schools.

The proposal, to the extent possible, shall incorporate existing models for effectively providing such services. Consultative services available under this proposal shall include emergency triage, prevention, early intervention and classroom-based approaches to behavioral health care, and shall provide effective behavioral health identification and treatment strategies for teachers, school staff and parents. The proposal shall be submitted to the secretary of health and human services by December 1, 2009.

SECTION 21. (a) There shall be an office of compliance coordination, within the executive office of health and human services, to provide administrative oversight, monitoring and implementation of the remedial plans and court orders related to *Rosie D. v. Romney*, 410 F.Supp.2d 18 (CA No. 01-30199-MAP) and the commonwealth's provision of early and periodic screening, diagnostic and treatment services for Medicaid-eligible children with serious emotional disturbances.

(b) There shall be a compliance coordinator in charge of the office, who shall be appointed by and report directly to the secretary of health and human services. The compliance coordinator shall: (i) facilitate compliance by MassHealth; (ii) serve as the primary liaison for any court-appointed monitor, special master or agent, and provide the court appointee with access to documentation in the possession of executive office, its agencies or their contractors needed to monitor compliance with the remedial plan or court orders; and (iii) promote consistency, where appropriate, with other state programs serving persons with similar service needs.

(c) The compliance coordinator shall issue semiannual compliance reports describing the commonwealth's compliance with the remedial plan and court orders and identifying any obstacles to compliance. The reports shall be submitted to the general court by filing with the clerks of the senate and the house of representatives, the senate and house committees on ways and means, the joint committee on mental health and substance abuse and the joint committee on health care financing.

SECTION 22. Section 18 is hereby repealed.

SECTION 23. Section 19 is hereby repealed.

SECTION 24. Section 20 is hereby repealed.

SECTION 25. Section 21 is hereby repealed.

SECTION 26. Section 22 shall take effect on November 1, 2009.

SECTION 27. Section 23 shall take effect on July 1, 2011.

SECTION 28. Section 24 shall take effect on December 2, 2009.

SECTION 29. Section 25 shall take effect on December 31, 2011.

Approved August 20, 2008.

Appendix B

The Children's Behavioral Health Advisory Council (the Council) was established under the provisions of Chapter 321 of the Acts of 2008. The Council is a unique public-private partnership representing child-serving agencies, parents and professionals with expertise in the issues of children's mental health. The membership of the Council is as follows:

Barbara A. Leadholm, *Chair* *Commissioner* Department of Mental Health	Gail Garinger *The Child Advocate* Office of the Child Advocate
Jan Nisenbaum Department of Children and Families Representative	Joseph Gold, MD *Board Certified Child Psychiatrist* Massachusetts Association of Behavioral Health Systems Representative
Janet George Department of Developmental Services Representative	Susan Ayers, LICSW Mental Health and Substance Abuse Association of Massachusetts Representative
Suzanne Fields Office of Medicaid Representative	Barbara Talkov Children's League
Anita Moeller Department of Early Education and Care Representative	Barry Sarvet, MD *Board Certified Child Psychiatrist* Massachusetts Psychiatric Society Representative/ New England Council of Child and Adolescent Psychiatry Representative
Nancy Schwartz Division of Insurance Representative	Michael Yogman, MD *Board Certified Pediatrician* Mass Chapter of the American Academy of Pediatrics Representative
Marcia Mittnacht *State Director of Special Education* Department of Elementary and Secondary Education Representative	Eugene D'Angelo, Ph.D. *Licensed Psychologist* Massachusetts Psychological Association Representative
Robert Turillo Department of Youth Services	Carol Trust, LICSW National Association of Social Workers – Massachusetts Chapter
Michael Botticelli Department of Public Health Representative	Dalene Basden Parent/Professional Advocacy League Representative
William R. Beardslee, MD *Board Certified Child and Adult Psychiatrist* Massachusetts Hospital Association Representative	Lisa Lambert Parent/Professional Advocacy League Representative
Timothy O'Leary Massachusetts Association for Mental Health Representative	Marylou Sudders Massachusetts Society for the Prevention of Cruelty to Children

Marylou Buyse, MD Massachusetts Association of Health Plans	Jeffrey Simmons, MD Blue Cross Blue Shields of Massachusetts Representative
Kermit Crawford, Ph.D. *Professional in human services workforce development* Boston Medical Center	John Straus, MD Massachusetts Behavioral Health Partnership Representative
Holly Oh, MD *Pediatrician from a Community Health Center* Boston Medical Center	Stephanie Morrill Young Adult Policy Team
Emily Sherwood *Director* Executive Office of Health and Human Services Children's Behavioral Health Interagency Initiative	Brandon Ekahtor Young Adult Policy Team
Valorie Faretra Department of Transitional Assistance	Lauren Falls Network Health
Deborah Weidner, MD Cambridge Health Alliance	Jill Lack Neighborhood Health Plan
Elizabeth Ross-Wong, MD Boston Medical Center HealthNet Plan	Karen Hacker, MD
John Sargent, MD	Midge Williams
Paul Shaw	Margarita Alegria
Sara Trillo Adams	Booker Lester
Roxana Llerena-Quinn, Ph.D.	Gisela Morales-Barreto, Ed.D.

Appendix C

Children's Behavioral Health Initiative Strategic Plan

Mission

The Children's Behavioral Health Initiative is an interagency initiative of the Commonwealth's Executive Office of Health and Human Services whose mission is strengthen, expand and integrate Massachusetts state services into a comprehensive, community-based system of care, to ensure that families and their children with significant behavioral, emotional and mental health needs obtain the services necessary for success in home, school and community.

Values

- **Family Driven, Child-Centered and Youth-Guided**
  Services are driven by the needs and preferences of the child and family, developed in partnership with families, and accountable to families.
- **Strengths-Based**
  Services are built on the strengths of the family and their community.
- **Culturally Responsive**
  Services are responsive to the family's values, beliefs, norms, and to the socio-economic and cultural context.
- **Collaborative and Integrated**
  Services are integrated across child-serving agencies and programs.
- **Continuously Improving**
  Service improvements reflect a culture of continuous learning, informed by data, family feedback, evidence and best practice.

Vision

The Children's Behavioral Health Initiative places the family and child at the center of our service delivery system, and will build an integrated system of behavioral health services that meets the individual needs of the child and family. Policies, financing, management and delivery of publicly-funded behavioral health services will be integrated to make it easier for families to find and access appropriate services, and to ensure that families feel welcome, respected and receive services that meet their needs, as defined by the family.

Strategic Priorities

1. Establish an Integrated Behavioral Health System
2. Increase Early Identification of Needs and Early Access to Appropriate Services
3. Expand Array of Community-based Services
4. Reduce Health Disparities
5. Promote Clinical Best Practice and Innovation
6. Strengthen, Expand, and Diversify Workforce
7. Mutual Accountability, Transparency and Continuous Quality Improvement

Strategic Priority 1: Establish an Integrated Behavioral Health System

Establish an integrated behavioral health delivery system across public agencies, payors and providers, which supports most appropriate, least restrictive service; integrated care planning; continuity of caregiver and setting; and efficient use of limited resources.

Strategies:

1. **Explore Opportunities for Leveraging Resources through Joint Purchasing,** including a possible Purchasing Collaborative with features such as multiple pathways to a single point of entry (no wrong door), common standards and integrated data system.

2. **Strengthen provider sustainability in delivering high quality, flexible services** through an integrated model/strategy for financing mental health services.

3. **Develop Interagency Protocols and Procedures:** Develop interagency protocols, training and conflict resolution process to ensure that children with behavioral health needs are identified early, supported into appropriate services and receive integrated care planning across agencies.

4. **Increase Capacity for Data-Sharing:** Develop mechanism for sharing Child and Adolescent Needs and Strengths (CANS) data across EOHHS child-serving agencies, as a first phase toward a more integrated data system.

5. **Build Local and Regional System of Care Infrastructure:** Build a regionally supported, local infrastructure to foster and sustain collaboration, service integration, and data-driven continuous quality improvement at the local level.

6. **Ensure Family-driven Care:** Involve families in policy development, service planning and monitoring at both the State and local levels of the System of Care.

7. **Increase Child in Need of Services (CHINS) and Detention Diversion for youth with significant mental health and substance abuse needs**

8. **Define Education Partnership Strategy:** In partnership with the Department of Elementary and Secondary Education and Department of Early Education and Care, develop an initiative to strengthen collaboration between schools, preschools and behavioral health services.

9. **Convene Private Insurers:** Develop a partnership between the State and private insurers around continuity of community-based care coordination and treatment for privately insured children with significant behavioral health needs.

Strategic Priority 2: Increase Early Identification of Behavioral Health Needs and Early, Timely Access To Appropriate Services

Establish community information networks that increase early identification and reduce the time it takes for families to locate appropriate services.

Strategies:

1. **Provide Universal Screening to MassHealth children and youth under 21:** Ensure that all MassHealth children receive a behavioral health screening as part of well-visits, and promote behavioral health screens with private insurers

2. **Educate Community Networks To Promote Early Intervention and Referral**: Engage and educate pediatricians, public schools, daycare centers, juvenile courts and probation, faith and community organizations to promote early identification, intervention and referrals to appropriate behavioral health services.

3. **Provide Family-Friendly Information on New MassHealth Behavioral Health Service and How To Access Them:** Provide MassHealth families with information on the menu of CBHI services in print, online, and in multiple languages.

4. **Foster a Family-Friendly Culture**: Gather and monitor feedback from families to ensure that services are welcoming, respectful and family-driven.

4. **Foster "Front Porch" Partnership Strategies To Decrease Disparities in Access**: Foster partnerships between providers and local leaders from communities of color and linguistic minorities, and promote other "Front Porch" strategies which increase access and ensure accountability for reaching all children in proportion to their presence in the population served by public sector agencies.

Strategic Priority 3: Expand Array and Capacity of Community-based Behavioral Health Services

Develop a comprehensive array of services for children on MassHealth and their families, building upon existing assets among community-based providers.

Strategies:

1. **Establish a Common Assessment of Strengths and Needs:** Provide consistent documentation of a child's strengths and needs, using Child and Adolescent Needs and Strengths (CANS) tool across all providers and child-serving state agencies.

2. **Build Statewide Provider Network To Deliver Effective Home and Community-Based Treatment Services:** With managed care entities and providers, build a network of family-driven home and community-based treatment services, built upon shared standards and informed by evidence and best practice.

3. **Embed Care Coordination within all Core Clinical Service:** Offer care coordination in an array of core clinical services to address the varied clinical needs of children and families.

4. **Strengthen Outpatient Therapy Service:** Develop a 3 year plan to strengthen of children's outpatient services to integrate family-driven, trauma-informed practice and care coordination, consistent with CBHI values.

5. **Develop Policies and Practices For Pre-school Aged Children, and Transition-Aged Youth and Their Families:** Develop policies and practices which address the specific needs of these age-specific populations.

Strategic Priority 4: Reduce Behavioral Health Disparities

Adopt and promote an array of best practices for reducing disparities in service access, availability, utilization and outcomes at all levels of the System of Care.

Strategies:

1. **Cultivate Leadership To Address Health Disparities At All Levels**

2. **Develop Capacity for Data Analysis of Behavioral Health Disparities:** Define disparities benchmarks, monitor relevant data by race and ethnicity, and initiate interventions to reduce disparities within CBHI state agencies and new services.

3. **Increase Availability and Use of Culturally and Linguistically Appropriate Services:** Expand the network of providers and services which meet the needs of diverse communities to ensure system-wide accountability for serving all children in proportion to their presence in the population served by public-sector agencies.

4. **Promote Best Practices for Reducing Health Disparities Among State Agencies, Managed Care Entities, Providers and Staff:** Integrate education and training on best practices in reducing behavioral health disparities in all levels of CBHI staff training, Children's Behavioral Health Research Center, provider development, managed care quality improvement activities.

5. **Diversify Behavioral Health Workforce:** Implement policies that values experience along with education or licensure, removes participation barriers for skilled, potential providers and staff, and creates new pathways for future workforce.

Strategic Priority 5: Promote Clinical Best Practice and Innovation

Cultivate a statewide learning community that fosters best practice through ongoing peer exchange, technical assistance, training and research.

Strategies:

1. **Provide Training and Coaching During Initial Service Expansion:** Support the large-scale start-up of new services across the state through training of directors, supervisors, front-line staff and child-serving agency staff to promote the delivery of new services with quality and fidelity.

2. **Establish a Children's Behavioral Health Research Center:** Develop a Center to promote performance improvement and best practices through learning communities, trainings, technical assistance, and collaboration with research institutions.

Strategic Priority 6: Strengthen, Expand and Diversify Future Workforce

Partner with higher education institutions to expand interest and understanding of the mission, values and work of a System of Care, and to create pathways to help diversify the future workforce.

Strategies:

1. **Higher Education Curriculum Initiative**: Partner with higher education institutions to foster cross-disciplinary education on System of Care, wraparound and cultural/linguistic competency research and best practice.

2. **Remove participation barriers for skilled, experienced providers and staff:** Development of a career pathway, potentially through partnership with community colleges. Define licensure waiver process for experienced clinicians from other countries.

3. **Establish Online Opportunities for Continuing Education**

Strategic Priority 7: Mutual Accountability, Transparency and Continuous Quality Improvement

Monitor results and use data to drive continuous improvement in practice and policy at the state and local levels.

Objectives:

1. **Develop evaluation plan and infrastructure:** Develop a plan and infrastructure for analyzing data and monitoring child, family and system-level outcomes, including policies for engaging outside researchers in studying aspects of the children's mental health system.

2. **Establish systems for data sharing, accountability and transparency:** Develop dashboard reports on key indicators and outcome measures to be shared with local Systems of Care, and key stakeholders including family and youth, legislators and the Children's Behavioral Health Advisory Council.

3. **Develop Disparities Reduction Benchmarks and Monitor Relevant Data by Race, Ethnicity and Language:** Develop and implement a plan to monitor disparities in service access, availability, utilization and outcomes.

4. **Use Data to Drive Improvements in Clinical Practice:** Promote innovation in clinical strategy and in health care purchasing, using clinical and financial data to improve quality and to design efficient payment incentives.

Appendix D

CBHI Advisory Council
Clinical Working Group Final Report & Recommendations

April 2008-March 2009
(Revised May 15, 2009)

Overview

In March, 2008, the Children's Behavioral Health Initiative Advisory Council established a Clinical Working Group charged with the following task.

Clinical Working Group Mission: Provide guidance on an array of clinical program design issues regarding the new Remedy services, starting with the design and delivery of Intensive Care Coordination (ICC).

The Clinical Working Group met monthly from April 2008-March 2009. The full membership of the Clinical Working Group (attached) included over 40 individuals, Meetings consistently drew an average of 20 people, including a solid core group of about 15, and another 20+ individuals that attended as their schedules would allow. Participants were largely clinicians, program managers and family partners of large and small provider agencies, consistent representation of 2-5 family members, and the active participation of at least 1 or 2 MCEs at most meetings. The Director of the Children's Behavioral Health Initiative attended the vast majority of the meetings, or was represented by the CBHI Deputy Director.

The Clinical Working Group drew regular participation from across the state, with steady involvement from Worcester, Springfield, New Bedford, Lynn, Quincy, Cambridge and Boston. The meetings were also remarkable for their strong ethnic and racial diversity, and a rich expertise and commitment to defining barriers and strategies to reduce health disparities and increase the cultural capacity of the Children's Behavioral Health Initiative. The theme of reducing health disparities was a consistent thread that ran throughout the wide-ranging discussions. This theme is reflected in the attached Summary of Recommendations.

The Clinical Working Group wishes to thank the numerous guest presenters, both nationally known trainers and researchers, and local practitioners from MA provider agencies who generously shared their time and experience on specific questions of practice or training.

The following Report summarizes the key recommendations made to CBHI over the course of the past year. Some of the recommendations were addressed as part of Remedy program design, while others remain to be addressed.

The Future of the Clinical Working Group

The March 2009 meeting of the Clinical Working Group focused in part on the future of the group. Nine of the members of the original Clinical Working Group are members of the new Children's Behavioral Health Advisory Council, while another dozen active

Working Group members are not part of the Council. The Clinical Working Group proposes that it be empowered to serve as the foundation for a future CBH Committee on Reducing Health Disparities of the new CBH Advisory Council. In this new capacity, some members of the Committee on Reducing Health Disparities will serve as liaisons to other Committees, helping to bring this perspective, voice and expertise to the overall work of the Advisory Council.

Summary of Recommendations

Recommendations Re: CSA and ICC Staff Qualifications

1. **See attached letter dated *May 1, 2008*** for detailed recommendations.

Recommendations Re: Policy and Regulations

1. **Re-align the outpatient system, so as to better support the other changes in the system.** Regulatory requirements for the outpatient system reflect a very traditional practice. However, the state of the art has evolved considerably over the past 20 years, and the State's requirements do not support or incentivize the provision of creative, diversionary services.

2. **Review and revise licensing regulations and their impact on providers (DPH clinic licensing, DMA Mental Health Clinic regulations and other regulations impacting Medicaid providers.)**
    - This issue was initially of particular concern as it might have impacted the CSAs capacity to deliver at scale and to address health disparities. Partly due to the feedback of the Clinical Working Group, the final specifications for CSAs and inhome therapy do not require clinic licensure. The initial recommendations included:
        - **For each CBHI service, determine whether the requirement of "licensed clinic" is appropriate.** There are providers delivering mental health services and family-based services who are not licensed clinics. They don't bill insurance, but are funded through contracts. Don't cut these providers out of the system.
        - **Provide technical support to help smaller organizations walk through the licensing process.** It doesn't have to take 2-3 years. Foster partnerships between those who have done it and those who want to do it.
    - Regardless of decisions regarding <u>new</u> services, a review of regulatory issues related to clinics and Medicaid providers is still needed. The current regulations create unnecessary financial and administrative burdens for all providers, as well as a particular challenge for smaller, culturally focused providers. There are similar barriers for satellite clinics.

3. **The business trend toward "bigger" agencies contradicts the need to reduce health disparities. Develop policies that preserve the financial viability of**

smaller providers. These providers frequently serve specific sub-populations that may be difficult to reach in other ways.

- Explore models for support a healthy relationships between lead and smaller, subcontracting agencies. Both the larger (lead) and the smaller, subcontracting providers need a new business model that addresses the cost constraints of the system.

4. **Institute performance incentives in Managed Care contracts to ensure that CBHI is serving all segments of the population proportionately.**
   - MCO should be held to SAMHSA cultural competency standards (attached) and accountable for assessing disparities in whom is served, access, utilization levels and outcomes.
   - MCO networks need to expand to include smaller providers with deeper reach in communities of color. The response that "our network is closed" is not adequate.
   - Consider using the framework of "Affirmative Marketing Plans", as used in other parts of state government. Build capacity of providers to reach specific communities.

Recommendations Re: Clinical Practice and Research

1. **Institute the evaluation of trauma and violence exposure trauma (individual, family and community trauma), and trauma-informed treatment within behavioral health practice in CBHI.** Trauma-informed policies and training should inform practice and reflect the context within which the family and child live.

2. **Examine how state system policies can foster an organizational culture within the system that supports community-based, family driven, culturally-informed practice.** This should be a key mandate for the CBH Center for Excellence/Research & Training Ctr.

3. **Ensure that Evidence-based Practices** be examined through the lens of whether they are culturally-informed and have been adequately tested with specific minority populations**.** Put process in place to ensure that culturally-informed best practices should inform policy decisions on EBPs.

4. **Ensure that the CBH Research Center** develops written policies to ensure that all research is culturally informed, transparent and accountable to the communities being studied. This includes whether they are conducting research initiatives that are participatory, community-based research in best practices for serving children and families of color within the CSAs. Establish collaborations with researchers who have expertise in working with culturally and ethnically diverse communities.

Recommendations Re: Workforce

1. **Test strategies to incentivize the development of a diverse workforce**. Encourage other MCE's to adopt MBHP's model of readily providing waivers allowing license eligible providers to bill for services, especially foreign trained clinicians who are not licensed in the US (under supervision from licensed clinicians). Bilingual clinicians who are originally from other countries are a resource that should be tapped. Consider establishing a center or clearinghouse to expand capacity to expedite credentialing of immigrant clinicians.

2. **Evaluate credentialing criteria, including "life experience" in staff qualifications, along with educational criteria, both regarding staff selection and compensation.**
   - Policies should support compensation for family partners for years of experience.

For bachelors level positions, explore further whether a BA is a meaningful indicator of the skills required for the role, and whether "life experience" might provide an equal or stronger set of skills for those roles.

Recommendations Re: Reducing Disparities

1. **Invest in tracking, analyzing and addressing health disparities at the EOHHS system level, Managed Care level, and local provider level.** Start by defining what are the service and outcome racial and ethnic health disparities. Accountability through data is central. Build capacity to analyze and disseminate data to look at trends in racial and ethnic health disparities. Use data to guide the development of systemic interventions to reduce health disparities.

2. **Support a collaborative process of engagement and peer learning** (rather than a punitive approach) to help providers strengthen their capacity to reduce disparities. CBHI's systems approach should reflect the reality that disparities are embedded in broader social conditions, so multiple strategies are needed to address them. There is no "quick fix", and at the same time, we are all accountable for our results.

3. **Strengthen policies regarding payment for interpreters.** Access to language capacity is a critical component of quality behavioral health services and essential for avoiding medical errors in diagnosis and treatment.

4. **Policies and financial incentives should foster cross-cultural partnerships** and collaborations at the local level to improve children's behavioral health outcomes

Recommendations Re: CANS Implementation

1. **Generally positive response to the tool itself.**
    - CANS can help strengthen the focus of clinical practice to a more strengths-based approach.
    - Explore additional support tools beyond CANS. (s.a. Hopkins Symptoms checklist, Harvard Trauma questionnaire, MBHP social adjustment tool for refugees and immigrants) Add components such as Columbia Impairment Scale, the Service Batteries, as well as parent satisfaction with quality and access to care, to better capture outcomes.

2. **Review frequency of use of CANS for individual families.** Eliminate redundancies.

3. **Addition of acculturation and cultural formulation sections to CANS strengthened the tool.** Additional input should be sought for next version of CANS.

4. **Strengthen the cultural competency of CANS trainings.** Bias in interpretation and decision making by clinicians will be reflected in CANS data. The bias is not in the instrument, it's in the clinician. If we're relying on CANS as a key data source, how do we address this? Training in cross-cultural practice for clinicians is critical.
    - Need to add CANS trainers with experience working in cross-cultural settings who can apply CANS in these settings.
    - Current trainers need better understanding of new sections added on acculturation and cultural formulation.
    - Need to develop vignettes designed to get at cultural issues. Current scenarios invite stereotyping.
    - Families and parents should be involved as co-trainers. Provide abbreviated CANS trainings for parents to teach parents what to expect from providers and how to be better informants.

5. **Concern about how CANS will be used as a tool to measure outcomes.** Bias in interpretation and decision making by clinicians will be reflected in CANS data. The bias is not in the instrument, but in the clinicians. If we're relying on CANS as a key source of data, training in cross-cultural practice for clinicians is critical. Direct family feedback is critical additional data.

Recommendations Re: Training

1. **Provide training in Culturally Responsive Practice for all services**
    - Research shows that training on culturally responsive practice needs to include multiple sessions over time in order to make a difference. It cannot be a one-shot or only a brief add-on to ICC or other service-

specific training. People need to learn, try out new strategies and come back to reflect on what works and what doesn't.

- Training should focus at the practice level, beginning with training in ones own social identity development. Start by studying self, and developing self-awareness of the lens that the clinician brings to the relationship. How the learner situates him or herself. How to recognize the clinician's own culture, along with the family's culture and mental health system's culture. Should explore how cultural context impacts clients and can be reflected in clinical practice.
- Implement training models that reduce stereotypes, rather than reinforce them. Identify what is the relevant knowledge needed for working within a community, and how to find out how this individual family is similar to and different from "the community." Foster understanding of multiple identities. Needs to acknowledge the complexity of power and privilege in all dynamics.
- Training should support a safe environment for learning, with each person coming to the table with their own biases, recognizing that we all have built in biases.
- Create and support a diverse learning community of practitioners focused on reducing health disparities. There is no one "expert." We need to learn from one another.
- Training alone will not reduce health disparities. It needs to be one strategy within a larger set of strategies.
- Evaluate the impact of training. Did anything change?

2. Parents as paid co-trainers

- Trainings, at all levels, should involve parent leaders as co-trainers.

Massachusetts Children's Behavioral Health Advisory Council
Clinical Working Group

May 1, 2008

Dear Commissioner Leadholm:

The Clinical Working Group of the Children's Behavioral Health Initiative Advisory Council appreciates the request for input into the design of ICC services. We are very pleased that the Clinical Working Group reflects a broad, diverse group of practitioners, including program directors, clinicians, family partners and managed care organizations from communities including Springfield, Worcester, Lynn, South Shore, Boston and Cambridge. Our discussions have been very lively and engaging for all who participated.

The Clinical Working Group is offering the following recommendations regarding Intensive Care Coordination services, based on our two Working Group sessions and feedback from the full Advisory Council. It is worth noting that the RFI responses included several similar recommendations to those outlined in this letter, including those submitted by providers who were not part of our Working Group.

Qualification for Community Service Agencies (CSAs)

While the list of qualifications in the Request For Information certainly describes the ideal provider of Intensive Care Coordination (ICC) services, we are concerned with the likely shortage of providers across the state that meet these qualifications. The current qualifications should be retained as the ideal provider, and also as the goal toward which all providers are expected to work.

We recommend that you define minimum requirements for the lead provider with regard to readiness to implement the ICC model. In addition to infrastructure, QM and clinical capacity requirements, we propose that the lead provider of ICC services meet the following minimum qualifications:

1. Demonstrated readiness to develop and deliver Wraparound services within a system of care, as evidenced by:

a. A track record of consumer and/or parent and/or youth voice within the organization's governance structure, service delivery model and/or evaluation mechanisms
b. Current strengths-based, family-focused practice and service models within the organization
c. A track record of sustained, innovative partnerships with community organizations in CSA's geographic area, such as schools, children and family service providers, mutual aid societies, faith institutions or other community programs.

While wraparound is a particular program model for which organizations may or may not have received funding, the practices described above define a philosophical alignment

with the wraparound/system of care approach that will be critical to successfully implementing the ICC program.

2. Demonstrated readiness to respond to the unique needs of the predominant racial, ethnic and linguistic populations (population critical mass) in the CSA's geographic area, either directly or through subcontract, as evidenced by:

a. Current cultural & linguistically tailored program models, for which current program staff and management reflect the cultural and linguistic populations served and/or a track record of funded partnerships with minority community-based organizations, mutual assistance agencies, or multi-service agencies for immigrants and refugees to meet the care and support needs of clients
b. Bilingual/bicultural staff for population critical mass and/or interpreter services for linguistic populations in the area for whom the organization does not currently have appropriate or adequate bilingual/bicultural staff.
c. Any cultural or linguistic competency plans and initiatives undertaken within the past two years to strengthen cultural and linguistic competency or capacity.

While no organization is likely to have cultural and linguistic capacity to all segments of the community, the lead organization must demonstrate a pro-active commitment to working with culturally and linguistically diverse families, and ability to partner with other organizations to address gaps in capacity.

Inclusion of "Best Practice" Programs

It is our concern that the infrastructure and capacity requirements for a CSA many result in excluding many of Massachusetts "best practice" programs in wraparound, systems of care, and culturally & linguistically affective services. We believe it is in the best interest of the CBHI system of care to engage best practice organizations that have a proven reach and effectiveness with the various populations of children and families. In this regard, we offer three recommendations:

1. **Feasible Financial Model for Subcontracting:** In addition to defining the selection criteria, the Clinical Working Group urges MassHealth to develop a financially well-designed model for subcontracting as one way for CSAs to meet the above-mentioned qualifications. Our experience also tells us that there is a power imbalance between lead agencies and smaller organizations that is too frequently reflected in inadequate financial arrangement between the lead and its subcontracts. Recognizing the administrative and training demands on the CSA lead agency, it will be nonetheless be important to ensure that the ICC clinical services provided by subcontractors are fairly compensated. We urge MassHealth to be proactive in ensuring that the proper balance is reached between the lead agencies and subcontractors.

2. **Mobile Specialized CSAs:** There are currently a handful of organizations across the state that serve a critical regional function in meeting the linguistic and/or medical needs of specific populations of children with SED. The Clinical Working Group recommends that in addition to the 29 geographically targeted

CSAs, that CBHI select approximately a half-dozen statewide Mobile Specialized CSAs that can partner with the 29 geographic CSAs to address significant gaps in capacity.

In addition to meeting the standard CSA qualifications, these Mobile Specialized CSAs would meet specialized qualifications for ICC team capacity to serve either:

a. major cultural & linguistic populations with identified behavioral health disparities coupled with a scarcity of culturally competent clinicians or dual diagnosis medical conditions (including autism spectrum, mental retardation parent/child mental illness, substance abuse)

3. **Hold MCE's Accountable to Build CSA Network Capacity to Address Disparities Over Time:** We were pleased to learn that data will be segmented to allow monitoring of utilization and outcome disparities for each CSA. We recommend that the RFR not be viewed as a fixed and final mechanism for defining the CSA, and that training, capacity-building, expansion of subcontracts and regional/mobile CSAs be included as tools to address gaps in service capacity over time. We recommend that the Managed Care Entities be held accountable for strengthening the provider network over time to work with culturally and linguistically diverse families in accordance with the principles, standards, performance indicators and outcomes as articulated by the SAMHSA's *"Cultural Competence Standards in Managed Mental Health Care for Four Underserved/Underrepresented Racial/Ethnic Groups"* (summary attached).

Qualifications for ICC Care Managers and Family Partners

a. Care Manager Qualifications

The Clinical Working Group strongly recommends that the Care Manager qualifications should not exclude those Masters level clinicians without licenses if they can demonstrate that they meet the competency requirements through both training and experience to deliver the services. Recognizing the child clinician labor shortage, in general, and in particular, the shortage of family-focused & culturally/linguistically competent clinicians, it is critical that we not erect unnecessary barriers to accessing qualified clinicians.

We recommend that Care Managers should have Masters level clinical training and experience, but should not exclude those w/o licenses, as long as they are under supervision of licensed clinician. The CSA's should make use of experienced clinicians from other countries. Some programs have even imported clinicians from Latin America and provided legal support to help them secure Green Cards to address lack of linguistically competent clinicians. (This is not meant to imply that linguistic competency is a sufficient qualification to serve as a Care Manager.) In addition, some Massachusetts Masters-level clinical programs are not designed lead to licensing, but students may not realize this when they select a program. Some clinicians with degrees from these programs have excellent experience, and it is a mistake to exclude them from the pool. MBHP has a strong track record in waiving the licensing requirement for

qualified clinicians. We support their approach to this issue, and would like to see all the other MassHealth managed care organizations adopt this model.

Future discussions of the Clinical Working Group will be looking at the competencies required for the ICC clinical position. Our current assessment is that a Bachelors of Social Work alone does not provide adequate training and experience for this role. One CFFC provider accepts a BA in Social Work combined with 4 years relevant work experience.

b. Family Partner Qualifications

The Clinical Working Group benefited from the participation of 4 practicing Senior Family Partners in this discussion. There was consensus within the Clinical Working Group that Family Partners must have SED experience, due to the particularly strong stigma and unique challenges associated with a child with SED. The Clinical Working Group recommends:

1. Use of the broadest definition of SED in defining "caregiver experience"
2. If the child meets the definition, then the Caregiver meets the qualification, even if the family doesn't identify with the label of SED. It is important that the qualifications defined in such a way that recognizes the cultural/linguistic constraints of the SED language, and that families from some cultures may not identify with the language of "Serious Emotional Disturbance".
3. Specify that the qualification is for a PRIMARY caregiver. For example, the sister of a primary caregiver who occasionally helps out with the child does not qualify. However, all primary caregivers would qualify, whether they are the parent, grandparent, foster parent or other relative who has served as the primary caregiver.
4. The group felt that the current CFFC qualifications for Family Partners were generally appropriate and should be replicated for the new ICC services. The specific qualifications mentioned by the group include:
    - Experience navigating the system
    - Demonstrated initiative to learn new advocacy skills through trainings. (No specific training is needed prior to hiring, but a constant learning of new information is necessary to be successful in the position.).
    - Strong connection to the community and knowledge of community resources.

Other Recommendations Regarding ICC

1. **Clarify what we mean by Cultural Competency** and how to assess whether a program/staff member demonstrates those competencies. Define cultural competency as not just about race, linguistics, ethnicity but about understanding the family, their class experience, their view. Provide clinical training around class and about cultural competency, more broadly.
2. **Include parent support groups as a service within the ICC package of services.** This is needed for post-ICC support through parent groups, and for

IDEA eligible kids that have less intensive needs and don't require ICC. It is, of course, less expensive than ICC, and may be the best service for some families.

3. **Ensure that flex funds are available** for those no longer in ICC, or who don't require ICC. Can flex funds be provided for siblings?
4. **Change the regs on satellites** with MBHP, DMA and DPH. This is a problem for large-scale ICC.

Thank you for you consideration on these issues.

Roxana Llerena-Quinn and Gisela Morales-Barreto
Clinical Working Group Chairs

SAMHSA

Summary of Cultural Competency Standards in Managed Mental Health Care for Four Underserved/Underrepresented Racial/Ethnic Groups

a. Organization governance and infrastructure, resources, policies and procedures, and oversight mechanism to deliver culturally and linguistically competent care.
b. Continuous quality improvements on cultural and linguistic competence as indicated by: organizational self-assessment, tracking and maintaining access, utilization and client satisfaction data on populations served.
c. Establishment of effective working relationships and exchange of information with local community based organizations as indicated by: cultural and linguistic appropriate mental health education, outreach, engagement and support.
d. Recruitment, retention and advancement of culturally and linguistically staff that is reflective of the population served. To ensure that all staff, governing entities, managers, and other service providers within the CSA have the requisite attitudes, knowledge, and skills for delivering culturally competent services.

Appendix E

Children's Behavioral Health Advisory Council
Committee Action Plan

Committee Name	**Culturally Informed, Best and Promising Practices Committee**
Chair(s)	Barry Sarvet, M.D. Peter Metz
Mission	The mission of the Culturally Informed Best and Promising Practices Committee is to formulate recommendations for the development and promotion of culturally informed best and promising practices within the system of care for children with emotional and/or behavioral health problems and their families and supports that promote wellness and prevention, based on System of Care values and principles and existing and ongoing evidence of effectiveness.
FY 10 Priorities	• Define essential elements or standards, which could be used to guide the selection of best and promising practices for funding or development. • Identify systemic and organizational structures and processes that can support the implementation and sustainability with fidelity and continuous quality improvement of best and promising practices, to be responsive to scientific evidence and the needs of consumers, practitioners, and provider organizations.. • Provide recommendations in coordination with the Data and Outcomes Subcommittee and the Children's Behavioral Health Initiative (CBHI) Center for Excellence on Research and Training on outcome measures and research/evaluation strategies for establishing an evidence base for CBHI services. • The scope of practices should include all stakeholders supporting children's emotional and behavioral health including education, child welfare, juvenile justice (including probation), early childhood, public health, and pediatrics, in addition to mental health systems. Attention will also be given to the needs of caregivers of children with mental health and substance abuse problems. • Emphasize recommendations for best and promising practices that will address health disparities, in collaboration with the Committee on Healthcare Disparities Reduction and Elimination.

Children's Behavioral Health Advisory Council
Committee Action Plan

Committee Name	**Legislative and Regulatory Committee**
Chair(s)	Susan Ayers Nina Rosenberg
Mission	The mission of the Committee is to identify rules and requirements that are unnecessarily burdensome or restrictive, and impede the delivery of and access to safe, effective and high quality children's behavioral health services, and to assist the Children's Behvaioral Health Advisory Council in the development of a reasonable plan, perhaps requiring legislation or regulatory action, to eliminate or reduce the identified barriers.
FY 10 Priorities (*through 6/30/10)*	Our initial focus will be on current licensing, regulatory and contractual standards, and operational requirements including those pertaining to staff or program credentialing or accreditation, that unreasonably impede and add unnecessary cost to the delivery of or access to children's behavioral health services. • Identify no fewer than three requirements that present barriers to the provision of and/or access to effective, safe and high quality services. • Conduct a comprehensive review with particular attention to discrepant or conflicting requirements and staffing requirements, from a variety of perspectives (consumer; service provider; managed care/purchasing entity; regulator). • Develop and present to the Children's Behavioral Health Advisory Council a written plan, including, when necessary, proposed legislation or regulatory changes, to reduce or eliminate the barriers. • Depending upon the time required to complete these initial tasks, the Committee will perform a similar identification and review process of standards for children's behavioral health services. • The Committee, on its own initiative, or at the request of the Council, the Legislative or Executive branches will be available to review and comment or related legislation upon request.

Children's Behavioral Health Advisory Council
Committee Action Plan

Committee Name	**Child Systems Integration Committee**
Chair(s)	John Sargent, M.D. Joe Leavey
Mission	To facilitate systems integration for children and families health and behavioral health locally, regionally, and statewide.
FY 10 Priorities (*through 6/30/10)*	• The committee will review current collaborations among all secretariats and state agencies with child serving responsibility* to ensure the most efficient and effective approach to enhancing children's behavioral health across the state. • The committee will review funding mechanisms, operations and relationships among state agencies and providers and private agencies to identify barriers to effective function and to develop solutions which improve behavioral health outcomes for children and families. • The committee will review the operation and funding process of the CBHI as a model of the transformation of the children's behavioral health system toward greater integration and collaboration. During this review issues that will need resolution will be identified and potential solutions will be suggested. • Regional differences in operation and collaboration will be reviewed and specific solutions to enhance integration locally and regionally will be identified and reported to the Advisory Council. • Legal barriers to seamless system responses to specific child and family problems will be identified and reported for potential statutory remedy. o This includes but is not limited to DMH, DPH (including BSAS), DCF, DYS, DESE, DEEC, DDS and the Office of the Child Advocate.

Children's Behavioral Health Advisory Council
Committee Action Plan

Committee Name	**Insurance Committee**
Chair(s)	Karen Darcy Marylou Sudders
Mission	Chapter.321 of the Acts of 2008 created the CBHAC and requires it to offer recommendations to the Administration and the Legislature, including recommendations that directly or indirectly impact private and public payers. Toward this end the Committee will embark on a gap analysis of children's mental health services and provide recommendations to the Council.
FY 10 Priorities (*through 6/30/10)*	***To date*** there has been agreement on the committee's mission, guiding principles and the decision-making process. The guiding principles are to: • Ensure that the standards of behavioral health care are consistent across public and private payers; • Ensure that the standards of behavioral health care and the full spectrum of cost-effective services are accessible, readily understood by, and regularly disseminated to all families regardless of race, ethnicity, or primary language; • Ensure fair and equitable behavioral health coverage and range of services across the system; • Ensure that family practice and pediatric primary care providers have adequate support to identify, diagnose, treat (where trained and qualified) or refer youth with behavioral health conditions; • Ensure that, regardless of changes in payer, any youth engaged in an ongoing course of behavioral health treatment is assured continuity of care for that treatment; and • Ensure that payers support active communication, consistent with HIPAA and applicable privacy laws and standards, between treating behavioral health clinicians and the caretakers of youth in treatment at any level of care. ***FY10 priorities:*** 1. To finalize a set of high level questions to be used in a survey of insurers; 2. To identify gaps in children's mental health services; and 3. To develop reform recommendations for consideration by the Council Executive leadership.

Children's Behavioral Health Advisory Council
Committee Action Plan

Committee Name	**Healthcare Disparities Reduction and Elimination Committee**
Chair(s)	Roxana Llerena-Quinn, Ph.D. Sara Trillo Adams, MA
Mission	To make recommendations to the Children's Behavioral Health Advisory Council for the identification and reduction of racial and ethic disparities in child behavioral health at all levels of the system of care in the Commonwealth
FY 10 Priorities (*through 6/30/10)*	• To develop a logic model for understanding disparities. • Request and review available data to identify racial and ethnic disparities in child behavioral health pertinent to access, utilization and outcomes. Recommend elements for data collection standards for all state agencies that will facilitate the measurement and monitoring of disparities. • To monitor impact of CBHI on disparities and make recommendations by: o Identifying what's working o Identifying elements of CBHI that may contribute to disparities • Make recommendations to increase awareness of behavioral health disparities at all levels of the System of Care. Include communication of data on disparities to the Advisory Council. • Work in collaboration with all Children's Behavioral Health Advisory Council committees and the Children's Behavioral Health Advisory Council to ensure integration of recommendations to reduce racial and ethnic disparities.

Children's Behavioral Health Advisory Council
Committee Action Plan

Committee Name	**Data, Trends and Outcomes Committee**
Chair(s)	Karen Hacker, M.D. Timothy O'Leary
Mission	The Data, Trends, and Outcomes Committee is dedicated to (1) promoting the use of evidence based practice (EBP) for the provision of children's behavioral health services for all children and families in Massachusetts; (2) the review, and evaluation of data pertaining to the delivery of children's behavioral health services in Massachusetts; (3) the development and promotion of a Children's Behavioral Health Research Center at the Department of Mental Health; and (4) the development of indicators, and outcome measures to evaluate the effectiveness of children's behavioral health services in the Commonwealth.
FY 10 Priorities (*through 6/30/10)*	• Review, comment, and make recommendations, if any, of all reports mandated by the legislation (c 321 Acts of 2008) • Develop appropriate questions for inquiry regarding the mental health status of Massachusetts children and families • Request, review, and interpret all relevant data pertinent to the mental health of Massachusetts children and their families. • Based on the aforementioned integration of data, recommend action to the Children's Behavioral Health Advisory Council. • Recommend design, structure, mission and vision of the Children's Behavioral Health Research Center to the Children's Behavioral Health Advisory Council for implementation. • Monitor the availability of child/family evidence based or evidence informed practices in the Commonwealth and elsewhere. • Commence work on the development of indicators and outcomes to evaluate child and family mental health services in the Commonwealth. An important goal of the Committee is to establish a system or procedure so that in 2 to 5 years we are not just measuring or demonstrating fidelity to a particular service model, but able to answer questions such as: • Have we made things better for children? • Which elements contribute to better outcomes? • How do parents and professionals (starting from different places) change in the interactions that the children's behavioral health services will promote? • How are these changes associated with service utilization and outcomes in children? Whenever possible, the Committee will attempt to measure progress against national metrics for children's mental health.

Children's Behavioral Health Advisory Council
Committee Action Plan

Committee Name	**Workforce Development Work Group**
Chair(s)	Kermit Crawford, Ph.D.
Mission	To recommend strategies to the Children's Behavioral Health Advisory Council which address workforce development needs and reduce and/or eliminate gaps for new CBHI services.
FY 10 Priorities (*through 6/30/10)*	• To assess workforce gaps in providing services to current CBHI population with the following characteristics: o The need for a diverse workforce/career pathways including language/cultural issues; o Clinicians with interest and skills in team-based, community, home-based services. • To identify short and long term resource-related recommendations to reduce and/or eliminate work force shortages (current and future), such as but not limited to: o Funding child clinical internships and supervision; o Expanding funding stream for collateral services in child casework; and, o Incentives to attract and sustain career child clinicians. • To identify future needs and project 3 – 5 year gaps in workforce • resources and recommendations for reduction and/or elimination. • To operationally define "clinical child providers", "family providers", "paraprofessionals", "age-related specialties", "disability", "targeted diagnosis populations".