Commonwealth of Massachusetts

Executive Office of Health and Human Services

THE CHILDREN'S BEHAVIORAL HEALTH ADVISORY COUNCIL

Annual Report 2011

The Commonwealth of Massachusetts

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Hon. Brain S. Dempsey, Chair, House Committee on Ways and Means

I am pleased to transmit the third annual report of the Children's Behavioral Health Advisory Council (Council), established under the provisions of Chapter 321 of the Acts of 2008.

Last year's report outlined comprehensive and detailed recommendations from the Council's committees. Some of these recommendations are under active consideration by the Legislature, while others are setting the framework for additional research and policy discussions among Council members. Currently, the Council is engaged in a prioritization process for the recommendations made and referenced in last year's report.

The Council will continue working on this process, as well as on a possible adjustment of its committee structure to eliminate overlap and create a sharper focus on issues of paramount concern and priority.

This year's Report continues the practice of previous reports and provides an overview of the progress made and challenges remaining on implementation of the services under the Children's Behavioral Health Initiative (CBHI), which are the core of the Remediation Plan (Plan) that resulted from the *Rosie D* federal litigation. While its purview is considerably broader than CBHI and the Plan, the Council has always been an interested observer and commentator because it recognizes that the CBHI services may become the blueprint for improving behavioral health services for all of the children of the Commonwealth with emotional disorders, and their families.

In addition, the Council has used this Repot to signal its interest in certain issues impacting children's mental health beyond the public delivery system. These issues include a review of the enforcement and implementation of the Commonwealth's mental health parity laws, including Chapter 207 of the Acts of 2010 relative to Insurance Coverage for Autism and ongoing strategies to ensure that as health care coverage and reform is extended and implemented throughout the Commonwealth, children's mental health is at the policy making table and is not treated as an afterthought. Because of the broad and diverse membership on the Council, I anticipate serious and thoughtful discussions on these and other issues over the course of the next year.

While the challenges facing the child and adolescent behavioral health system are significant and complex, progress is being made as a result of the energy, dedication and commitment of Council members and many others, who have extended their time and expertise to the work of its standing committees.

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 continue our work to develop a comprehensive, integrated community-based system of care – one that is accessible and responsive. And, one that provides children and adolescents with behavioral, emotional and mental health needs, and their families with the services and supports 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 AND PRELIMINARY STATEMENT

Section 1 of Chapter 321 of the Acts of 2008 amended Chapter 6A of the Massachusetts General Laws, by inserting Section 16Q and 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 section 16Q (a) states the Council is to, "advise the governor, the general court and the secretary of health and human services." The scope and breadth of the Council's advisory role is best evidenced in subparagraph (d) of Section 16Q, which authorizes the Council to make recommendations in the following areas:

(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.

The Council believes it is vital to its mission, and ultimately to the families and children of the Commonwealth, that its members, policy makers and others keep in mind 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 legislation, policies, practices and procedures that best serve the families and children of the Commonwealth with emotional disorders and behavioral health needs. While our policy recommendations may be tempered by fiscal realities, they should not depend upon who is governor, who is the 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.

Because of the *Rosie D* litigation, considerable attention has been paid to the public delivery of care system and to the creation, and penetration of the new services created as part of the remediation plan under that litigation. While the Council shares that interest and gives it due attention, we are very much aware that those new services are only available to families and children covered under MassHealth, and, as the enabling provisions of the law that created us make clear, our purview is much broader than the *Rosie D.* case and the Children's Behavioral Health Initiative. ***Accordingly, we need to focus appropriate attention on the families and children who are covered by commercial carriers.***

This is particularly true where the Commonwealth, indeed the nation, is beginning the implementation of health coverage reform. As terms such as integrated care, medical home and accountable care organizations become part of our health care nomenclature, we need to pay attention to and understand their impact on children's mental health.

Moreover, the enactment of legislation such as mental health parity and, more recently, Chapter 207 of the Acts of 2010 relative to insurance coverage for autism, prompts us to ask questions about implementation, enforcement and whether or not the intended purposes of these pieces of legislation have been realized. These questions and discussions need not commence or proceed in an adversarial way, but rather in a fashion utilizing the Council's professional diversity, and its common interests in improving the mental health of all the Commonwealth's children. Only through extensive and thoughtful examinations and discussions – those designed to illicit information, understanding and perhaps consensus – as opposed to simply articulating current opinions, biases or practices - can we hope to offer policy makers and others the kind of guidance and recommendations the Council was established to provide.

PART II. ROSIE D. V. PATRICK (F/K/A ROSIE D. V. ROMNEY)

In 2002, a class action lawsuit, *Rosie D. v. Romney,* was filed in the federal court by **parents 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 disturbances. The Commonwealth was also 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, which would have delayed 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 has been appointed to oversee the implementation of the remedy.

It is not surprising, given the fact the remediation plan is being implemented in the context of litigation, there is disagreement between plaintiffs and the defendants as to the degree of success or shortcomings in how the plan is being implemented, the penetration rate of the new services as well as how does one (or when does one) begin to assess whether or not the new services are having a positive impact on the children and families they are designed to serve. Simply stated, it is not the Council's role to resolve these differences, nor frankly is it equipped to do so. There are websites, readers of this report can access to view current (sometimes conflicting) information on the implementation of the Commonwealth remediation plan. Two such websites are:

- http://www.mass.gov/?pageID=eohhs2subtopic&L=4&L0=Home&L1=Government&L2=Special+Commissions+and+Initiatives&L3=Children's+Behavioral+Health+Initiative&sid=Eeohhs2

- http://www.rosied.org/

The Council receives periodic data reports, which provide information on the number of screenings and assessments, the number of children receiving a particular service(s) and other information. We have set forth a summary of this information below.

(A) (Utilization of new Medicaid (CBHI) Services
Reporting Period is July 1, 2010 through March 31, 2011 (Revised August 15, 2011)

It should be noted that while the numbers within a particular CBHI service are unduplicated, there may well be duplication among all the services since individuals or families may have received more than one of the listed services. Moreover, Family Support and Training is not a "stand alone" service, but rather is provided as needed in conjunction with Intensive Care Coordination.

Finally, it should be noted that in comparing the following data one should keep in mind that what is being compared are the first 9 months of FY 2011 with the complete FY 2010 year.

CBHI Service	**Unique Utilizers 7-1-10 to 3-31-11**	**% of Eligible Members**	**Unique Utilizers 7-1-09 to 6-30-10**	**% of eligible members for FY 2010**
Intensive Care Coordination	7,469	1.51%	6,479	1.35%
Family Support and Training	6,269	1.27%	5,281	1.10%
In-Home Behavioral Services	699	0.14%	242	0.05%
Therapeutic Mentoring	4,996	1.01%	2,735	0.57%
In-Home Therapy	9,949	1.79%	7,492	1.44%
Youth Mobile Crisis Intervention	8,591	1.55%	9,727	1.87%
All CBHI Services	21,126	3.81	18,473	3.54%

(B) Crisis Stabilization

One of the services under the remediation plan – Crisis Stabilization – has yet to commence and the Court has scheduled a September 2012 hearing on this issue.

Initially, the Commonwealth requested the Centers for Medicare and Medicaid Services (CMS) to approve a state plan amendment that included this service, and sought federal reimbursement for all of the room and board costs inclusive in the service. Because the Medicaid statute does not cover room and board costs, CMS informed the defendants that it would only approve the service, if the room and board costs were removed.

Rather than accepting this result, the Commonwealth agreed to request federal funding for Crisis Stabilization Services, including room and board costs, as part of its waiver renewal application to CMS. Once again, CMS refused to approve the service unless MassHealth excluded room and board costs.

In response, MassHealth modified its waiver application and deleted Crisis Stabilization Services altogether.

At a June 2, 2011 hearing, the Court expressed serious concern that this mandated service had not begun, and that there appeared to be no reasonable prospect for it being offered to children who desperately need this program in the event of a crisis. The Court instructed the parties to report at the September hearing on options to address this gap in the mental health system.

(C) Screenings

According to the August 26, 2011 CBHI Update, over 300,000 behavioral health screens are now performed each year. The rate of identification of potential behavioral health need is in the 7% - 8% range, which is consistent with published research on other behavioral health screening programs.

(D) Wraparound Fidelity Index

The Wraparound model of care is an integral part of the remediation plan and each year, the Commonwealth is required to measure and report to the Court on the fidelity of the service providers to the model. MassHealth, through its Managed Care Contractor, is using two state-of-the-art assessment tools for measuring whether the Intensive Care Coordinators providers conform to the standards of High Fidelity Wraparound: (a) the Wraparound Fidelity Index 4.0 (WFI-4) and (b) the Team Observation Measure (TOM).

Approximately, 600 families were contacted by telephone to complete the WFI-4 and each Community Service Agency has been required to complete two TOMS on each of its care coordinators. The data collection was to be completed by the end of June 2011, with the results to be announced in the fall of 2011.

Last year, Massachusetts scored slightly higher than the national average on 9 out of 10 Wraparound Principles

RECOMMENDATION: The Commonwealth should make its data information available on the CBHI Website noted above), or at some other suitable location, for those who are interested in more immediate access to this information.

(E) Council's Activities and the Children's Behavioral Health Initiative Team.

To the extent possible, the Council's committees, interact and collaborate with state agencies and the Children's Behavioral Health Initiative Team, in particular Emily Sherwood. This has resulted in some positive changes. For example:

- The Council's Racial and Ethnic Health Disparities Reduction and Elimination Committee collaborated to change the CANS Instrument to account for youth from different cultural backgrounds. The Department of Mental Health (DMH) and the Department of Children, Youth and Families (DCF) will be using this new version of the CANS. The work is completed and training will commence in the fall of 2011.
- Similarly, The Council's Culturally Informed, Best and Promising Practices Committee developed a structure and guide for evidenced based practices, which has proven helpful to the delivery of In-Home Therapy under the Remediation plan.
- The Child System Integration Committee is collaborating with EOHHS, legislators, and others in connection with an initiative to improve the delivery of children's services.

(F) Data, Racial or Ethnic Disparities, and Outcome Measurements

The Council believes there is a critical need for the Commonwealth and in particular, the Executive Office of Health and Human Services to build a suitable information technology infrastructure for the accumulation and sharing of data between and among the EOHHS child serving agencies. We will never know how the children of the Commonwealth with behavioral health needs are doing until we can see accurate and unduplicated data.

While, as noted above, improvements have been made, particularly with regard to the CANS instrument, we will not be able to adequately identify racial or ethnic disparities without data more comprehensive than what exists today. The Council's Racial and Ethnic Health Disparities Reduction and Elimination Committee has aggressively advocated for better data, and is engaging in initiatives with other Council committees to sharpen the focus on disparities. **A copy of the Committee's August 2011 Report is attached as Appendix B**

The Council's Data, Trends and Outcomes Committee is developing a "logic model" outlining the kinds of outcomes, data collection tools and indicators we need to look at in the immediate, near and more distant future to make determinations as to whether or not these new services have improved the mental health of the children and families receiving them. We fully appreciate the difficulty of ascribing any change in child functioning to any particular service, but we believe the enormity of time, energy and public resources being expended to comply with the Court's order require that we measure more than fidelity to a model and more than family or customer satisfaction. We need to put in place a mechanism that will allow future researchers and others to determine whether or not children's mental health improved as a result of these efforts and services.

(G) Conclusion

Council members continue to be impressed with the energy and professionalism of those charged with the responsibility of implementing the remediation plan. This is important, complex work being performed under tight guidelines and the unblinking eye of a federal court. While much remains to be done, and the fact that the crisis stabilization services have yet to commence is troublesome, we believe all who have been involved at any level of the transformation that is occurring should be congratulated for what has been accomplished to date in an economic environment that would have produced failure but for their efforts.

PART III. CHILDREN NOT COVERED UNDER ROSIE D V. PATRICK

Much has been said or written about the *Rosie D* case and the new Medicaid services offered as part of the remediation plan. The Council needs to pay due attention to both because (1) they are transforming the public mental health system for children, adolescents and their families; and (2) they are potentially creating the blueprint for improving the system for all of the children and adolescents of the Commonwealth.

However, what should not be forgotten is that these services are only being offered to those children and adolescents covered by MassHealth. We know there are a large number of children and adolescents whose mental health care is not part of a remediation plan being monitored by a federal judge, a court appointed monitor or by a team of attorneys representing their interests.

We believe part of the Council's mission and charge is to ask, among other things:

- How are those children and adolescents not covered by Rosie D doing?
- What can be done to improve the children's behavioral health system for *all* children in the Commonwealth with emotional disorders and behavioral health needs?

What follows is a preliminary and conceptual narrative on potential agenda items and topics for the Council to address in the year ahead as it focuses on the above two questions:

(A) <u>Commercial Insurance Carriers</u>

In last year's report, we set forth a series of recommendations from the Council's Committee on Insurance, all of which were adopted by the Council. These recommendations were made with a focus on those children and families not covered under the remediation plan. We believed then and now they are responsive to the Council's charge, and we hope they will continue to receive serious consideration and support from legislators, state officials, advocates and others.

While the Council continues to support the recommendations outlined in last year's report, this seems an appropriate time for the members to begin a discussion among themselves, and others as to how best to ensure that whatever gains or progress that are made in the public delivery of care system are, at a minimum, at least considered and examined by commercial carriers with a view towards extending them to its subscribers.

Marylou Sudders, the CEO of the Massachusetts Society for the Prevention of Cruelty to Children, a well-respected former Commissioner of the MA Department of Mental Health and a member of this Council, observed at a legislative hearing:

> If I had a child with a serious mental illness or serious emotional disorder, I would rather that child be getting services through the Commonwealth's public mental health system than to rely on my commercial insurance carrier.

In spite of budget shortages and a national recession, the Massachusetts public behavioral health system has and continues to transform itself to a system where clients (patients), family and parents are the focus of treatment planning; where services are flexible and client centered; and where peers (others with mental illnesses) and parent partners (other parents with disabled children) are now part of the recognized treatment team and valued participants in the effort to help others achieve recovery. These dramatic changes resulted from actions taken by dedicated state officials (legislative & executive), advocates, the disability community and litigation.

Ironically, all of these changes are occurring in the public sector, while perhaps more than 70% of children, adolescents, adults and seniors who need mental health services are covered by private or commercial carriers, and, in large part, do not have access to these cost effective and affordable services.

Over the next year, the Council hopes to organize a collaborative consortium of clinicians, business people, insurance and managed care entity executives and others to commence a dialogue and a policy consensus initiative with the goal of providing all children and adolescents with emotional disorders access to effective behavioral

healthcare treatments whether they are insured by a commercial provider or under MassHealth.

It should not take an Act of Congress or the Massachusetts State Legislature to compel commercial insurance carriers to treat mental illnesses and emotional disorders the same as other covered illnesses, but it did. Why?

There is little to be gained by assuming it was because of insurer indifference or animosity. The fact is commercial insurers operate under fiduciary obligations and constraints very different from what exists on the public side. We hope more conversation and collaboration will create greater understanding of these factors and lead to a plan or process through which a greater utilization of advances in children's mental health can be achieved.

While members of the Council actively advocated passage of mental health parity (both in 2000 and 2008), many also believe that a collaborative process with candid discussions and working groups dealing with credentialing processes, medical necessity requirements or other issues will promote greater understanding among all stakeholders as to the barriers and concerns that prevent consensus and how they can be resolved. Moreover, such a process could result in long-term policy solutions more flexible and cost effective than legislative pronouncements and more adaptable to future changes in medical knowledge about behavioral healthcare treatments and practices. In brief, stakeholders with the common interests of promoting access to affordable, cost effective treatments might create more long-term change working collaboratively rather than opposing each other on pieces of legislation.

The Council, though this initiative, could also become a productive vehicle to review and comment on a number of issues, including implementation of the parity laws, as well as the recent legislation on Autism (Chapter 207 of the Acts of 2010).

(B) Medical Home, Payment Reform, Accountable Care Organizations and Children's Mental Health

As the Commonwealth continues with the implementation of federal health reform, as well as payment reform, the Council should be vigilant that children's mental health – indeed all behavioral health – is at the policy and decision making table. We need to guard against the unintended consequences that often result when mental health is simply "lumped in" as part of primary health. Some quick examples of topics that could occupy the Council's time in the coming year include:

- The opportunities presented in the federal Patient Protection and Affordable Care Act for Pediatric Accountable Care Organizations warrant the Council's examination or discussion as to the potential impact on children's mental health and how such organizations might be structured or organized.

- A Pediatric Medical Home will necessarily look different from the Medical Home envisioned for adult patients; how will resources be allocated and how does children's mental health fit in?
- The real (or perceived) lack of relevant and validated risk adjustment methodologies for pediatrics raises issues about global payment models. If risk cannot be accurately determined, how can resources be allocated fairly?

These and other issues have been raised and discussed by several organizations in policy reports, white papers and advocacy briefs.[1]

We are grateful for the assistance and support we have received from Barbara Leadholm, Commissioner of the Department of Mental Health and EOHHS Secretary JudyAnn Bigby, M.D., Chris Counihan, Director of Behavioral Health/MassHealth, Emily Sherwood, Director of Children's Behavioral Health Interagency Initiatives, and the other wonderful people at EOHHS, DMH and the child serving agencies within EOHHS. Special thanks to Carol Gyurina (MassHealth), Joan Mikula, Lester Blumberg, Stephen Cidlevich from DMH, for their professionalism, patience and graciousness in helping the Council and for all they do for the children and families of the Commonwealth.

[1] See, for example: The ACA's Impact on Medicaid: Changes and Opportunities for MassHealth Massachusetts Medicaid Policy Institute (July 2011) Massachusetts Chapter of the American Academy of Pediatrics, Medical Home White paper, (2009) http://www.mcaap.org Making Payment Reform Work for Children with Mental Illness Children's Mental Health Campaign (August 29, 2011)

LIST OF APPENDICES

APPENDIX A

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 Commission 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	Joseph Gold, M.D. Massachusetts Association of Behavioral Health Systems Representative
Janet George Department of Developmental Services	Vicker DiGravio III Association for Behavioral Healthcare Representative
Christopher Counihan Office of Medicaid	Barbara Talkov Children's League of Mass Representative
Anita Moeller Department of Early Education and Care	Peter Metz, M.D. New England Council of Child and Adolescent Psychiatry Representative
Nancy Schwartz Division of Insurance	Barry Sarvet, M..D. Massachusetts Psychiatric Society Representative
Marcia Mittnacht Department of Elementary and Secondary Education	Michael Yogman, M.D. Mass Chapter of the American Academy of Pediatrics Representative
Robert Turillo Department of Youth Services	Eugene D'Angelo, Ph.D. Massachusetts Psychological Association Representative
Michael Botticelli Department of Public Health	Carol Trust, LICSW National Association of Social Workers – Massachusetts Chapter
William R. Beardslee, M.D. Massachusetts Hospital Association Representative	Dalene Basden Parent/Professional Advocacy League Representative
Timothy O'Leary Massachusetts Association for Mental Health Representative	Lisa Lambert Parent/Professional Advocacy League Representative
Emily Sherwood Director Executive Office of Health and Human Services Children's Behavioral Health Interagency Initiative	Marylou Sudders Massachusetts Society for the Prevention of Cruelty to Children

Sarah Gordon Massachusetts Association of Health Plans Representative	Jeffrey Simmons, M.D. Blue Cross Blue Shields of Massachusetts Representative
Kermit Crawford, Ph.D. Professional in human services workforce development Boston Medical Center	John Straus, M.D. Massachusetts Behavioral Health Partnership Representative
Holly Oh, M.D. Pediatrician from a Community Health Center The Dimock Center	Stephanie Morrill Young Adult Policy Team
Joel Goldstein, M.D. Cambridge Health Alliance	Emily Russell Young Adult Policy Team
Amy Carafoli Boston Medical Center HealthNet Plan	Lauren Falls Network Health
John Sargent, M.D.	Jill Lack Neighborhood Health Plan
Margarita Alegria	Karen Hacker, MD
Roxana Llerena-Quinn, Ph.D.	Midge Williams
Paul Shaw	Gisela Morales-Barreto, Ed.D.
Sara Trillo Adams	Booker Lester
Gail Gall	Kathleen Regan
Toni Irsfeld	Mary Ann Gapinski

Children's Behavioral Health Advisory Council Committees

Peter Metz, Co-Chair Barry Sarvet, Co-Chair	Culturally-informed, Best/Promising Practices Committee
Nina Rosenberg, Co-Chair Toni Irsfeld, Co-Chair	Legislative and Regulatory Committee
Joseph Leavey, Co-Chair John Sargent, Co-Chair	Child Systems Integration Committee
Karen Darcy, Co-Chair Marylou Sudders, Co-Chair	Insurance Committee
Sara Trillo Adams, Co-Chair Roxana Llerena-Quinn, Co-Chair	Healthcare Disparities Reduction and Elimination Committee
Timothy O'Leary, Co-Chair Karen Hacker, Co-Chair	Data, Trends and Outcomes Committee
Kermit Crawford, Chair	Workforce Development Committee

APPENDIX B

Children's Behavioral Health Advisory Council (CBHAC)
Racial and Ethnic Health Disparities Reduction and Elimination Committee
August 4, 2011

As described in the 2010 Children's Behavioral Health Advisory Council Report, the Racial and Ethnic Health Disparities Reduction and Elimination Committee had three priorities:

1. To analyze CBH data for racial and ethnic disparities;
2. To identify best practices and system barriers to serving racially and ethnically diverse families with the new CBH services, as a roadmap for further action;
3. To improve the CANS instrument and training to encourage the culturally appropriate exploration of the needs and strengths of racially and ethnically diverse populations, informed by research.

In this report, we offer some recommendations based on the work of the Disparities Committee to date and utilizing the October 2010 Children's Behavioral Health Advisory Council Annual Report as a resource since its recommendations are pertinent to the work of the Disparities Committee and relevant to the overall work of the CBH Advisory Council.

The chairs of the CBHAC committees met with Secretary of Health and Human Services, JudyAnn Bigby, MD, in April 2011 and presented the recommendations of each of the committees. Following this meeting and based on the responses of the Executive Committee, the CBHAC discussed its priorities and possible next steps. Acknowledging that the work of reducing health disparities crosses over to the work of all the CBHAC committees, we call attention to the following recommendations of the Disparities Committee relevant to the work of the CBHAC as it moves forward:

1. Recommendations relative to identifying new resources to provide EOHHS and its agencies the capacity for interagency data analysis on access, utilization and outcomes by race, ethnicity and language (REL) for monitoring decreases and/or increases in racial and ethnic disparities.

Proposed Next Steps:

- The Committee clearly notes the need for resources for data collection, data sharing and analysis. Recognizing the legal and technical challenges of integrating data across EOHHS agencies and declining state financial resources, the CBHAC and its committees will continue to make an effort to work with the Administration and others to identify potential resources, statutory and policy changes and other actions needed to improve the capacity of EOHHS and its agencies for data collection, data sharing and analysis.

- The CBHAC has been informed that progress toward addressing the REL data issues has been made. The EOHHS Health Disparities Working Group, which comprises representatives of DMH, DPH, DYS and the CANS system, has aligned REL data. While DCF and MassHealth have not yet aligned REL data, the EOHHS Health Disparities Working Group will continue to work on addressing this. As progress continues to be made, the CBHAC will be updated on capacity for reporting CBH REL data to identify action steps to address health disparities.
- In July 2011, the Disparities Committee Co-Chairs received a "Distribution of race and ethnicity in CANS data" report for the period of 3/1/10 to 11/21/10. The report will be reviewed with CBH staff and shared with the Disparities and the Data, Trends and Outcomes Committees to identify next steps.

2. Recommendations relative to encouraging best practices and removing systems barriers to serving racially and ethnically diverse families:

Proposed Next Steps:

- The Disparities Committee proposes to work with CBHAC's Workforce Development, Data, Trends and Outcomes and Culturally-Informed Best and Promising Practice committees to create a Cross-Committee Work Group to focus on addressing key priorities of all four committees. Particularly, to monitor the quality of services and outcomes so that all children in the Commonwealth have not only access, but have CBH services that meet their needs. Evidence-based practices should be examined through the lens of whether they are culturally-informed and have been tested with specific minority populations. This proposed Cross-Committee Work Group can develop recommendations on strengthening ICC practice in assessment, diagnosis and medications monitoring. Additionally, diversifying the workforce to reflect the populations served is a priority of the Workforce Development Committee and the Disparities Committee.
- The CBHAC will begin discussions relative to cross-committee collaborations at their October meeting.

3. Recommendations relative to improving the CANS instrument and training to encourage the culturally appropriate exploration of the needs and strengths of racially and ethnically diverse populations, informed by research.

With the encouragement of CBHI staff and UMass CANS trainers, the CANS subcommittee was established to review the Acculturation Items of the CANS and recommend improvements in both the instrument itself and related training to reflect research and evidence on working with racially and ethnically diverse populations. The CANS revision has been completed and endorsed by Secretary JudyAnn Bigby, MD and the Executive Committee. The "Acculturation" domain has been replaced with a new "Cultural Considerations" domain and a series of test pilots have been conducted by the CBHI project team. The EOHHS-CBHI team and UMass trainers have been working with Dr. Kenneth Hardy, from Drexel University, to create on-line training modules.

Proposed Next Steps:

- The Disparities Committee Co-Chairs will work with the EOHHS-CBHI team to present the revised version of the CANS Cultural Considerations domain to the CBHAC and to the Disparities Committee.
- The CANS subcommittee emphasizes the need to ensure that CANS training team is diverse and has the needed expertise in this area. Committee members will continue to provide feedback in the design of the training as it gets ready for implementation and continue to consult with the CBHI team.

Respectfully submitted:
Roxana Llerena-Quinn and Sara Trillo Adams, Co-Chairs
Racial and Ethnic Disparities Reduction and Elimination Committee