Indiana Behavioral Health Commission

Meeting Minutes for April 10, 2024
Indiana State Library
315 W Ohio Street, Indianapolis, Indiana
Chairperson: Jay Chaudhary

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

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

Minutes

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

Commission Members Absent:
Steve McCaffrey

Meeting proceedings were:

Item 1: Welcome and Minutes

Jay Chaudhary welcomed everyone to the meeting and shared the meeting's focus on the mental health of individuals with intellectual or developmental disabilities (I/DD). He moved the motion to adopt the minutes of the previous meeting. It was adopted by Senator Andrea Hunley, seconded by Michelle Clarke, and all other members voted in favor.

Jay acknowledged that while system and federal challenges significantly limit State interventions, this meeting will bring suggestions to improve at the State level.

He also recognized the dedication of behavioral health providers and the State's role to support and help reduce barriers for providers in successfully serving individuals with I/DD.

Item 2: Overview of I/DD services

A. Dr. James Wiltz, PhD HSPP and co-founder of Kestrel Behavioral Health, gave an overview of the history of intellectual and developmental disability (I/DD) diagnoses.
    a. Historically, there has been stigmatization and a lack of differentiation in diagnoses between mental health conditions and intellectual and developmental disabilities (I/DD).
    b. Diagnostic overshadowing, when a mental health-related diagnosis is mistaken as part of an individual's I/DD, is prevalent and has created roadblocks to successfully treating individuals with I/DD.
        i. The term "dual diagnosis" was coined in 1982 and physicians did not regularly diagnose individuals with I/DD with co-occurring mental health conditions until the Diagnostic Manual - Intellectual Disability (DM-ID) was published in 2007.
    c. Individuals with I/DD have co-occurring mental health conditions at a higher rate than the average population. Mental health conditions are often overlooked in individuals with I/DD as they may present differently due to differences in cognitive and communication abilities.
    d. Individuals with I/DD can benefit from mental health treatment, including psychotropic medication and behavioral support. Distinguishing between behavioral and psychiatric needs is critical for care delivery.
B. Holly Wimsatt, Director of the Bureau of Disabilities Services (BDS) in the Division of Disability and Rehabilitative Services (DDRS), provided an overview of BDS including services and supports, eligibility criteria, upcoming waiver transitions, and the Bureau's ongoing initiatives.
    a. BDS services are available to individuals with an intellectual disability, developmental disability, or related condition that is expected to continue indefinitely and has an onset prior to 22 years of age. BDS services for individuals with I/DD include Intermediate Care Facilities, Home and Community-Based Services (including Family Support Waiver (FSW) and Community Integration and Habilitation Waiver (CIHW)), Supervised Group Living, Extensive Support Needs Facilities, and Comprehensive Rehabilitative Management Needs Facilities.
    b. BDS is transitioning several waivers in July 2024. Individuals aged 60 years and over, currently on the Aged & Disabled waiver, will transition to the PathWays for

Aging program. Individuals 59 years and under will transition to the Health & Wellness waiver. The Health & Wellness waiver and Traumatic Brain Injury waiver will move from Division of Aging oversight to DDRS oversight. FSSA has intentionally retained many aspects of the waivers to ensure a smooth transition for providers and individuals seeking services.

c. Ongoing initiatives include capacity building to assess current gaps in I/DD services in Indiana and subsequent training opportunities for providers; modernization of institutional settings; and waiver redesigns that consider current service gaps and opportunities for improvement.

Commission members raised questions about options available for individuals on the FSW waiver waitlist and concerns about payor for services outside of BDS.

- BDS shared that the FSW waitlist has only existed for a few years and is predominantly children 5 and under who are also eligible for First Steps services.
- For those not eligible for First Steps, BDS works closely to connect them to other available state and community resources that have options for school-based coverage, state plans for early screening and diagnostic services, and other Medicaid coverage based on eligibility.

Commission members discussed current barriers to modernizing BDS and DMHA institutional settings. Jay Chaudhary and Holly Wimsatt acknowledged the main barrier is federal codes mandating certain requirements for these institutions and emphasized that DMHA and BDS are focused on working better together to meet individual needs.

Jay then dismissed everyone for a 10 minute break.

Jay invited Kelly Hartman to share a phrase that has helped her understand different service models: “the umbrella of services is either held by the agency or the individual.” In institutional models, the service umbrella is held by the agency and clients are provided access to the agency’s array of services. In HCBS, the client holds the umbrella and requests their services and chooses their service providers.

Item 3: Moderated Discussion with Service Providers

Jay transitioned from the history of diagnoses and overview of services to the moderated discussion with current I/DD service providers:

- Megan Lauman, Behavioral Consultant with ViaQuest Community Solutions
- Katy Adams, President and CEO of Southwestern Behavioral Healthcare (SBH)
- Anne Titus, Vice President of Benchmark Human Services

Presenters shared current successful strategies and roadblocks in serving individuals with I/DD.

- Katy Adams discussed SBH's work with Easterseals Rehabilitation Center to provide an integrated outpatient Neurodevelopmental Center for youth with co-occurring I/DD and psychiatric conditions, using funding from DMHA's Community Catalyst Grants.
    - SBH recommended having an integrated, multidisciplinary team work together to determine an individual's treatment plan as it gets the right services in place from the beginning and saves time and money on unnecessary services down the line. As a result of this service model, 100% of the Neurodevelopmental Centers' caregivers feel confident in dealing with their child's complex needs.
    - Katy shared that a significant challenge is sustainable funding. The Neurodevelopmental Center was launched using grant funding. SBH recommended the best path to sustainable funding is through the Certified Community Behavioral Health Clinic (CCBHC) model, which offers a new payment model that SBH hopes would cover all service offerings of the Neurodevelopmental Center.
    - If DMHA is selected to be a part of the federal CCBHC Demonstration Program, Southwestern will become a CCBHC with funding to continue the model; however, if the CCBHC model is not expanded, SBH would need to secure other funding and determine have to figure out what services can be paid for and offered by the clinic.

- Anne Titus highlighted successes from the investment in mobile crisis, the increase in psychiatrists and therapists servicing individuals with I/DD, and a greater emphasis on holistic care of individuals with I/DD.
    - Anne Titus recommended an increase in access to mobile crisis services. Otherwise, individuals with I/DD may be served by staff members that are not trained or equipped to handle the situation or be given medication that is not coordinated with their regular service providers.

- Presenters emphasized the workforce is one of the biggest challenges in the behavioral health space is facing currently, though the state is making progress.
    - Megan Lauman noted that there are many providers that are willing to be educated on treating dually diagnosed individuals.
    - Katy Adams recommended additional training of the behavioral health workforce at all levels to serve individuals with I/DD and an emphasis on building community understanding of I/DD.

- Presenters further emphasized:
    - The importance of serving individuals not based on their diagnosis or insurance but instead based on their needs as a whole person.

- Individuals with I/DD and a co-occurring mental health condition may have their primary diagnosis overshadow any secondary diagnoses, making it difficult to access other services for the dual diagnosis. As an example, in acute/crisis care, individuals with I/DD may not be able to express their state of crisis due to different communication or cognitive abilities and therefore may be assessed as not needing services for their mental health condition.

Item 4: Innovative I/DD Service Models

A. Kelly Hartman, Vice President and Behavioral Health Consultant with ViaQuest Solutions, provided insight into current issues individuals face in I/DD service models and made recommendations for possible innovative solutions:
    a. Simplify the navigation of silos and embracing a "no wrong door policy" to reduce confusion and ensure individuals receive services no matter how they enter the system.
    b. Increase clarity and awareness on provider titles, care team roles, and disciplines creates cost savings, reduces duplicative efforts, and streamlines the process for individuals and families trying to navigate the system.
    c. Consider systemic gaps such as the lack of technical assistance and resources for individuals with I/DD in crisis. The Health Home Model could address some of these systemic gaps.
    d. Increase access to appropriate crisis response services and settings for individuals with I/DD, in home and community settings where possible. Due to a lack of crisis response services and supports for individuals with I/DD, these individuals are oftentimes escalated to an overly restrictive placement such as a Comprehensive Rehabilitative Management Needs Facility (CRMNF) for persons with developmental disabilities, State psychiatric facilities, or the Department of Corrections.
    e. Explore the possibility of a partnership between DMHA and DDRS to create a behavioral support technical assistance and resource team to serve as a preventative resource for providers serving families/individuals with I/DD. This would help reduce the costs of reactive healthcare and the number of individuals with I/DD hospitalized, institutionalized, or incarcerated.

Item 5: Public Comments and Workforce Strategies

Jay opened the floor up for any questions from the public and received none.

A. Gina Woodward, Director of Behavioral Health Workforce Development at DMHA, shared themes about the behavioral health workforce to close out the meeting.

a. The 2022 BHC Report referenced workforce as the biggest barrier to implementation. A skilled and passionate workforce ultimately improves access, continuity, and quality of care.
b. Systemic and sustainable workforce solutions are needed. Potential ideas include updating policy around education and licensing to reduce barriers in building the pipeline of behavioral health workers and investing in innovative workforce recruitment and retention strategies.

Item 6: Closing Remarks
Jay invited Commission members to share any final thoughts.

Senator Crider noted that Indiana has the opportunity to look at and address issues within the behavioral health workforce pipeline. He suggested addressing the current gap in trauma informed care training and considering licensing and education requirements to ensure there is a qualified workforce with the flexibility to respond to different needs.

Senator Hunley shared that the Commission should continue to consider populations such as the unhoused, those that are self-medicating, and those going through systems of incarceration and hospitalization. There is an opportunity to discuss how to use funds on preventative measures to reduce barriers and support vulnerable populations.

Jay closed the meeting by emphasizing the Commission's focus on operationalizing recommendations to support person-centered services for individuals with behavioral health needs.

Jay thanked the speakers and commission members for their time and input, shared details for the subsequent May 13th Commission meeting, and adjourned the meeting.