

Mental Health Transformation- State Incentive Grant
Workgroup #3. Disparities in Mental Health Services are Eliminated
Minutes, Meeting #1

Date: Thursday, March 09, 2006

Time: 9:00 am – 12:10 pm

Location: Connecticut Valley Hospital, Middletown, Page Hall Rm 213

Convener: Jose Ortiz

Scheduled Agenda

1. Welcome and Introductions
2. Ground Rules
3. Workgroup Charge
4. Group Discussion
5. Goals
 - a. Improve access to quality care that is culturally competent
 - b. Improve access to quality care in rural and geographically remote areas.
6. Meeting Schedule
7. Next Steps

1. Welcome and Introductions

Jose welcomed the members of the workgroup. He explained that this workgroup is part of a 5 year grant, \$13.7 million. The first year is focused on developing a report with recommendations. The team should aim to develop this report by May 2006; it will then be presented to the oversight committee. The product of this workgroup is not focused on developing services, it's about developing an infrastructure across state systems that aims at eliminating disparities; for example, training, technical assistance, technology, policy statements, etc. There are six workgroups. Jose explained that he is a "convener" as opposed to a "chair", and that members of the workgroup should let him know if they perceive that his ideas are influencing the process.

Members of the workgroup introduced themselves, mentioning their professional positions and some personal background. Many expressed excitement or strong personal interest in the topic of disparities and cultural competence. Members are from different service systems and state departments, and described expertise across the life span from youth to elderly.

2. Ground Rules

Jose reviewed with the workgroup a list of group rules and workgroup members provided feedback. *Agreed upon guidelines included:* be open, listen, and ask questions; avoid "blaming" statements; respect opinions you may not agree with; focus on the person speaking and don't interrupt; participate according to comfort levels; take a risk in sharing ideas as no idea is a bad one; put cell phones on vibrate or silent ring and take your call outside; say "ouch" if someone says something that is uncomfortable or offensive and educate others about that; share the time succinctly as this process is time-intensive; be punctual; have fun; avoid side conversations.

It was suggested that we should know ahead of time when breaks will be scheduled. *The workgroup agreed to take a break from approximately 10:15-10:30.*

A question was asked about the process of consensus and how dissenting opinions may be addressed or considered. Other members discussed the importance of verbally noting if they disagree with issues. Jose noted that he will consider how to incorporate this suggestion.

3. Workgroup Charge

A packet of materials was distributed, and contents were reviewed, including a paper on child recovery, the organizational chart of the Mental Health Transformation committee, descriptions on the workgroups, list of steering committee members, description of other workgroups, the President's Freedom Commission for Mental Health. Members were asked to read the information prior to next meeting, including the Freedom Commission for Mental Health.

Jose noted that the workgroup will meet regularly, and the conveners will meet every 2 weeks. Recommendations may overlap with the products from the other workgroups. Although we are not focusing on direct service delivery, there may be projects that target infrastructure that impacts services, such as telemedicine. This workgroup will cut across agencies and will address recommendations across the life span.

Jose clarified that we are one of 7 states that received the transformation grant. DMHAS is the lead agency, and this workgroup will develop a report with recommendations which will be reviewed by the oversight committee, which will then be submitted for approval to the federal government and then funding will be determined. For example, the process that the workgroup recommends may be to: ensure that data is "clean", then based on data analysis determine the race/gender/age disparities associated in the systems, then establish interventions to address those disparities. This workgroup will be a consensus-building process to produce an effective product, and thus "no idea is a bad idea."

It was suggested that we have a presentation that covers what are "health disparities" and differences between medical health and behavioral health disparities. Jose mentioned that a presentation will be provided next week.

6. Meeting Schedule

The workgroup discussed what a reasonable work schedule would be in order to produce this ambitious product. Although perfect attendance is ideal, it may not be possible. Attendees agreed to meet next week (March 16th), followed by every two weeks: March 30th, April 13th, April 27th, May 11th, May 25th, June 8th (if necessary). We will meet 9 am-12 pm. Jose will develop a timeline for steps in producing the product, including target dates for developing the drafts etc. CSSD in Wethersfield was offered as a possible location if CVH is not available. The group suggested other alternatives.

7. Next Steps

Representation of different groups was discussed. Next week two representatives from Khmer Health Advocates agency (focused on Asians) will join the workgroup. Jose will invite consumer representatives. It was suggested that someone from NAMI or another mental health consumer agency would be welcome. Other suggestions from the group were presented. Jose asked members to provide him with any recommendations for other group members, He also recommended that members should have meetings with their constituents and colleagues at their

agencies, including having focus groups, in order to obtain and exchange ideas that can inform the workgroup recommendations.

4 & 5. Group Discussion and “Goals”

The members divided into four breakout groups of four persons each to discuss the disparities in Connecticut and their respective agencies’ observations and experiences related to this issue, and to generate preliminary ideas that will feed into possible recommendations. Groups wrote a list of their ideas on flip charts. Members were encouraged to focus on the two goals of:

- Improve access to quality care that is culturally competent
- Improve access to quality care in rural and geographically remote areas

The executive summary of the Freedom Commission was referred to when discussing the goals. Improving access to quality care includes access and quality of care. Cultural competence should encompass multicultural groups such as gender, age, etc. Improving access to quality care in geographically remote areas may include, for example, areas of CT where there are Asians or Hispanics who don’t have access to linguistically- or culturally-competent providers.

Members discussed the process of the breakout groups. Some mentioned that it was difficult, particularly without having a broader idea and context of the transformation and the definition of disparities; others said it was somewhat overwhelming. Some mentioned that it was helpful and positive. Jose stated that this is a fluid process, and that the different ideas will be re-framed and concretized in order to feed into developing solid recommendations. Jose will bring the group’s lists of ideas back to the group next week. Other ideas can be added as the process continues.

Group one

Ideas offered by the group were the following:

- Identify barriers within organizations that prevent the delivery of multicultural services
- Funding sources should provide funding that best utilizes expertise of service provider agencies
- Standardize evaluation tools to identify common variables, in order to establish a baseline and track changes over time
- Agree on common terminology and key terms as they reflect access to services
- Infrastructure is important; there is a need to develop data systems and obtain technical assistance to analyze the data
- Perform a needs assessment to determine what different cultural groups need and want
- Partnerships should be established within agencies and organizations
- Education of staff and providers, as well as for clients, on cultural issues and the need to be culturally inclusive
- Statewide contracting standards/ language: there’s a need to have more standardization in regards to language that addresses cultural competence
- Develop a “State Office of Cultural Competency” to be a statewide resource across agencies. This would be different from an office that is subsumed by a particular state agency.

Group Two

This group discussed differences in behavioral health (focus is on access and quality of services) and medical health (focus is on differences in incidence and prevalence of specific medical conditions). Ideas were the following:

- Identifying what behavioral health disparities there are in Connecticut. For example, African Americans may be less likely to obtain atypical antipsychotic medications. The challenge in identifying behavioral health disparities is that the data available is lacking. Therefore, there is a need to improve quality of data in order to subsequently identify the disparities.
- Related to the above is the importance of monitoring quality of the data.
- Exploring factors across systems that influence disparities, including non-behavioral systems, such as employment, housing, education, nutrition, involvement in criminal justice system, etc. It will be important to identify the most critical areas that impact disparities. Probability matching across data sets across systems may be utilized to identify how disparities in one system for a person (or groups of persons) may impact or relate to disparities of the person (or groups of persons) in other systems. This would need matching of datasets.
- Increasing awareness, education and training; for example, relating to cultural competency as well as the nature of the disparities.
- Increasing access to best practices, developing toolkits that target particular disparities, and instituting outside monitoring of the effectiveness and quality of the interventions.

Group Three

This group focused on taking a broad perspective (e.g., across the lifespan), and suggested the following:

- Identification of what resources are currently available.
- Answering the question of “who serves whom?” and what kind of regulations and mandates impact which agencies serve which persons. Related to this is the identification of populations that are not served or underserved.
- Development of standards that define cultural competency in mental health services for citizens of Connecticut, across the life span. There should be a “gold standard” that is used as a template.
- Therefore, a needs assessment should be conducted to identify what is currently occurring across the life span that is culturally competent and inclusive of issues relating to gender, abilities, geography, abilities, socioeconomics, etc, and deliverable and appropriate to the demographics of the population. It is important to make sure that the needs assessment itself is culturally appropriate in order to ensure that the measurement focus and tools target the population in a sensitive manner.
- Resource mapping (this term also needs to be defined); there is need for the technology to support resource mapping as well as developing the technology that provides a bridge between the needs and the services. The process would include resource mapping, planning, and developing the resources.
- The overall process should use person-centered planning around infrastructure development. For example, making funding portable to follow the person’s individual desires and needs, and not the agency.
- Cross-agency communication.
- Community awareness and training to enable optimal access to quality and culturally competent care within a person’s home community.

It was emphasized that there is a need to acknowledge that evidence-based practices are not effective for everyone.

Group Four

This group discussed ideas relating to data needs and service access. Suggestions relating to data were:

- Meet the data needs and bridge the gaps in available data. This necessitates “clean”, multicultural data, whether services provided or not. For example, it’s important to collect data on people who do not access services or access services but do not continue with utilization. It is also important to have consistency of data across systems.
- In addition to formal data, there are also other data sources (Census, education) that may help us identify populations that we are not targeting or serving.

Ideas relating to access were:

- For service access, there should be efficient entry to the needed service with cultural, ethnic, and language matching. Also, need to improve quality of access based on analysis of “clean” data that identifies the disparities (e.g., who is not getting access).
- State agencies and regulations (e.g., Medicaid) create and reinforce the disparities and create fragmented services. This should be improved to obtain continuity of services.
- Importance of having congruency in responding to culturally determined needs across the systems
- Multidimensional assessment to serve multiple systems. Agencies serve many persons in common, although each agency has different intake and other forms, although such paperwork creates barriers to services. There should be a shared multidimensional assessment.

The workgroup discussed the need to develop core common data elements. It was noted that federal infrastructure initiative under the Block grant includes some of that. Medicaid also includes list of data elements.

Jose reminded the workgroup to read the packet materials before next meeting, and to discuss the content and workgroup ideas at their respective agencies.

**** Next Meeting is Thursday March 16, 2006, CVH Page Hall Rm 213. ****