CCBHC Steering Committee Meeting
Date: 9/4/2025
Time: 11am-12pm

Attendees: Robert Haswell, Lois Berkowitz, Nicole L., Ben Shaiken, Alexander L., Lynne Ringer, Shauna Pangilinan, Steve Lajoie, Mark Vanacore, Heather LaSelle, Stephney Springer, Renee Gorr, Caroline Anyzeski.

Notes:

1. Welcome and Agenda Overview
2. Workgroup Updates
    a. We will need to coordinate how to get workgroup updates to the steering committee.
    b. Will the workgroup group meeting minutes get posted? If that is an ask, we can coordinate how to get those posted.
    c. Crisis Services Workgroup
        i. The workgroup met last week and will be meeting this afternoon. The cadence will be weekly.
        ii. The workgroup reviewed the PowerPoint and began the discussion about the different components about crisis services.
        iii. The meeting this afternoon will present the work the administrative team has done around a visioning exercise for crisis services which includes the landscape as it is today in CT and inviting anyone in the group to add or adjust to what is included. There are decision points and suggestions for the group to consider.
    d. Veterans Workgroup
        i. The group began talking about stigma and how to engage the veterans. There was discussion about not having any people with military service at the table, this is one of the pieces that workgroup would like to bring.
        ii. A participant offered to engage and bring individuals from the Veterans Affairs (VA) which would help with coordination of care and assisting those new to this project that may need to figure out how to navigate through the VA.

iii. The workgroup also began looking at the CCBHC Certification Criteria and will be doing a cross walk between the criteria and the documents coming out of the VA, along with their expectations so that we can ensure that what the VA expects for treatment is met by the CCBHCs.

iv. There was a discussion about training and what kind of components of training are critical for the various parts of the organization.

v. Was there discussion about how you might coordinate with the federal VA? There is a provider who worked at a CT VA in Willimantic to connect with the group.

1. That contact would be great because because the other contacts are in West Haven and Newington, so that contact would be perfect.

e. Community Providers Workgroup

i. The workgroup reviewed a PowerPoint with the goals and tasks for the workgroup.

ii. The workgroup was provided the CCBHC Certification Criteria for their review.

iii. There was a discussion on what is working well with the CCBHCs and things to consider.

iv. The workgroup discussed engaging tribal communities, there was overlap and awareness that the Tribal communities are important.

v. It was suggested to possibly partner with law enforcement so that referrals into CCBHCs can happen and diverting them from law enforcement.

vi. Members of the workgroup shared experiences about going out into the community and having specific staff, such as community engagement specialists and peers, and also working with the schools.

vii. The workgroup also said the information from CONNIE for the individuals that are presenting at the ED so that there can be part of the coordination of care.

viii. It was talked about how the Community Providers Workgroup is more of a catch all. A question was raised about what the charge for this workgroup or all of the workgroups is about what their role is compared to the steering committee and the other workgroups. Should this be something we should develop? Maybe having a place where we can bounce ideas off each other and interaction between the workgroups.

ix. That is a good point, one of the things that came out of it is to review the CCBHC Certification Criteria. As state partners, maybe we can lay that out better and make it more manageable for each workgroup meeting. This is something the state partners will look at.

x. Maybe different things can be separated out such as primary care, or substance use disorder, or behavioral health. Possibly do different categories and focus them a little bit more.

xi. The workgroup decided to meet on the first and third Tuesdays of the month and plan to identify leaders of the workgroup next meeting.

f. Policy and Regulatory

i. The first meeting went over a high-level overview of what the workgroups are tasked with and the beginning steps.

ii. The workgroup identified that there are often disconnects between expectations from CT Department of Children and Families and CT Department of Public Health. There will be work done to pull that information together and identify the discrepancies.

iii. That will be looked at to see if there are places that changes can be made or evaluated to better understand how these two items are different.

iv. This workgroup will meet every two weeks.

g. Remaining workgroups

i. The remaining workgroups are working on being scheduled.

ii. The requests for availability for two more workgroups, the Evidence-Based Practice and Workforce Workgroup, were sent out. Hope to schedule those two weeks from now.

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h. Meeting Schedule

    i. Carelon created a meeting schedule with all the dates and the links.

    ii. This schedule will be updated as the workgroups are schedules.

3. Tribal nations Discussion

    a. From the Community Providers Workgroup, the question was asked regarding Tribal Communities. From the federal grant perspective, thinking about tribal nations focuses residents of tribal nations, when in other states there is a larger population when compared to CT. United Services, geographically the closest grantee to Mohegan and Mashantucket Pequot Tribe, said they work a little bit with them but Mohegan Tribe has robust internal behavioral health system. Mohegan Tribe said that if we have specific questions we can reach out. It might be helpful to talk to some of those folks in Mohegan health care system who are working with the people with serious mental illness (SMI) population.

    b. Almost one percent of the CT population live in the two tribal nations. Should the Tribal Communities Workgroup be its own workgroup or how should we integrate it with another and maybe do targeted outreach. Does anyone on the state side have any thoughts or feedback or how this should be structured?

    c. On the DCF side, we have meetings with representatives from tribal nations quarterly. They are interested but it is a challenging for time commitment for them. Having participated in the Community Provider Workgroup meeting, learning that the Mohegan tribe has a system of sort, it would be a good idea to either invite them to the steering committee to hear more about it or invite them to the provider workgroup and hear more about it. It might provide enlightenment for those providers doing the work. It has been suggested to reach out to other states and how they do it.

    d. I know Rhode Island is farther along in the CCBHC process than we are and I don't know what population of each state has of tribal nations but I know RI has a similar low tribal population and it would be a helpful question to answer.

    e. I like the idea of them coming to the provider meeting and folks hearing them out.

f. In some ways I feel like it is an overlap of the Veteran's population because it's how we are we helping them? Is it referring them services? Or the coordination of care component and how do you do that? And how to reach out to someone who isn't engaging in care but how to get them engaged? Working with Veterans, there are overlaps, may be a population that is disconnected from standard service.

g. They are different populations but similar access to healthcare. They have their own health services, but they may not offer as comprehensive array of health services particularly for those with SMI and need access to a CCBHC even though theoretically their healthcare is covered.

h. A member of the steering committee did reach out to providers back in June to see if they had expertise to share and did not hear back. That said, if anyone has additional thoughts as how to engage, please let us know. One is the time commitment, and the other is excavating information and expertise and managing what we are giving back for that information. Maybe can reach out again to see if we can get students because it is the school year again.

4. Request For Applications (RFA) Update

    a. DSS Contracts sent the RFA final summary to the DSS Commissioner, DCF Commissioner and DMHAS Commissioner for signature. Once DSS Contracts receive the signed summaries, they will notify the selected clinics and let the non-selected clinics know they were not selected.

    b. DSS will follow up on Monday with contracts because it was sent this week.

5. **Questions and Discussion**

    a. None

6. **Next meeting**: September 18th from 11 am to 12 pm