Service Array Notes – 5.6.2021

Meeting Recording:
https://rigov-my.sharepoint.com/:v:/g/personal/jason_lyon_ohhs_ri_gov/ESUWhzqVqWRGpLk_QT-EUcIBedIytM9nrnqH3nLnqsF25Q

Attendees

1. [Yesterday 2:58 PM] Cheryl Dill (Guest) was invited to the meeting.
2. [Yesterday 2:58 PM] Kelci Conti (Guest) was invited to the meeting.
3. [Yesterday 2:58 PM] Andrea Chait, Ph.D., BCBA-D, LBA, NCSP (Guest) was invited to the meeting.
4. [Yesterday 2:58 PM] Joseph Robitaille (Guest) was invited to the meeting.
5. [Yesterday 2:59 PM] Tara Hayes (Guest) was invited to the meeting.
6. [Yesterday 2:59 PM] Jessica Walsh NHPRI (Guest) was invited to the meeting.
7. [Yesterday 2:59 PM] Silver, Rebecca B (Guest) was invited to the meeting.
8. [Yesterday 3:00 PM] Reilly-Chammat, Rosemary (Guest) was invited to the meeting.
9. [Yesterday 3:00 PM] Carlene (Guest) was invited to the meeting.
10. [Yesterday 3:00 PM] Rosaly Cuevas (Guest) was invited to the meeting.
11. [Yesterday 3:01 PM] Margaret Holland McDuff (Guest) was invited to the meeting.
12. [Yesterday 3:01 PM] Jamie (Guest) was invited to the meeting.
13. [Yesterday 3:02 PM] Flanagan, Patricia J. MD (Guest) was invited to the meeting.
14. [Yesterday 3:02 PM] Jenna Nelson (Guest) was invited to the meeting.
15. [Yesterday 3:02 PM] Jennifer Levy (Guest) was invited to the meeting.
16. [Yesterday 3:03 PM] Shareen Holly (Guest) was invited to the meeting.
17. [Yesterday 3:03 PM] Beth Bixby (Guest) was invited to the meeting.
18. [Yesterday 3:03 PM] Helene (Guest) was invited to the meeting.
19. [Yesterday 3:04 PM] RLaRocco (Guest) was invited to the meeting.
20. [Yesterday 3:05 PM] Lee Robinson (Guest) was invited to the meeting.
21. [Yesterday 3:00 PM] Warner, Heather (DCYF) was invited to the meeting.
22. [Yesterday 3:01 PM] Ashlee Gray (Guest) was invited to the meeting.
23. [5/6 3:05 PM] Nidhi Turner, MSW, LICSW (Guest) was invited to the meeting.
24. [5/6 3:05 PM] Jessica Waugh (Guest) was invited to the meeting.
25. [5/6 3:06 PM] Joseph Weeks (Guest) was invited to the meeting.
26. [5/6 3:06 PM] Sandra Peltier (Guest) was invited to the meeting.
27. [5/6 3:10 PM] Renee Hanley (Guest) was invited to the meeting.
28. [5/6 3:16 PM] Gabriel Soden (Guest) was invited to the meeting.
29. [5/6 3:18 PM] Benedict Lessing (Guest) was invited to the meeting.
30. [5/6 3:29 PM] Becky Almeida (Guest) was invited to the meeting.

Meeting Chat:
[5/6 3:32 PM] Margaret Holland McDuff (Guest)
I dont think they talked to anyone at FSRI who has a wide array of BH services for children and adults

[5/6 3:32 PM] Flanagan, Patricia J. MD (Guest)
nor with pediatricians

[5/6 3:33 PM] Carlene (Guest)
They did not speak with St. Mary's either.

[5/6 3:44 PM] Benedict Lessing (Guest)
Faulkner did not speak with us either

[5/6 3:45 PM] Margaret Holland McDuff (Guest)

Yes Integrated Care and infrastucture to build it!!

[5/6 3:47 PM] Beth Bixby (Guest)
Workforce challenges need to be addressed in order to have adequate access and capacity

[5/6 3:48 PM] Nidhi Turner, MSW, LICSW (Guest)
https://www.mabhaccess.com/CBHI.aspx

[5/6 3:48 PM] Benedict Lessing (Guest)
We would also like to provide input to Faulkner. Ben Lessing
[5/6 3:49 PM] Margaret Holland McDuff
Workforce !!!! 100% Beth

[5/6 4:03 PM] Beth Bixby (Guest)
https://hassenfeld.bryant.edu/wp-content/uploads/2020/08/HumanServicesFinal.pdf

[5/6 4:03 PM] Beth Bixby (Guest)
Here is the workfdorce report

Meeting Notes
Jason Lyon: Introductions in the chat, and then introduce yourself before speaking.

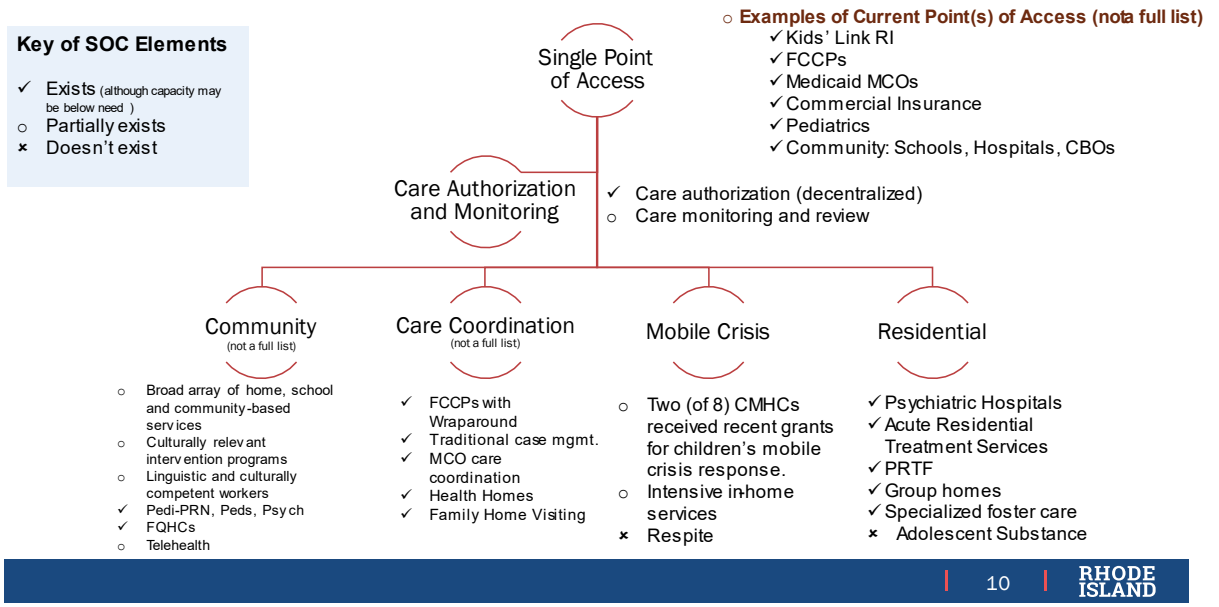
These Service Array meetings are scheduled through August – 4 of them.

There are 7 workgroups. We'll be taking notes, so that when the state folks get together to pull all this info together, each group can share notes with each other. We'll make sure we're all on the same page so that each is equally influencing all of the outcomes. Keep us honest for folks with the different groups.

Purpose of the Group: The idea for these sub-groups is to come together to discuss how to make positive change, sustaining change and be forward looking. We wouldn't be having this discussion if things were wonderful and good. So, we want to collectively keep that in mind. We'd like to be able to have discussions and focusing on future planning – not just rehashing what has not worked. We'll ID them in the present.

Also, I want to plant a seed: from the state's perspective, we are hoping to have co-chairs of the sub-groups of a community partner. Folks who are interested – you can start thinking about it.

To go back to our original presentation of the Children's Behavioral Health System of Care, here are the core elements:



On the single point of access. It's not a physical place, but somewhere to have the initiation of services and can triage to the proposed System of Care in the future. There are some examples, including KidsLink, FCCPs, etc.

Another group is Care Authorization and Monitoring, which we'll be able to collaborate with.

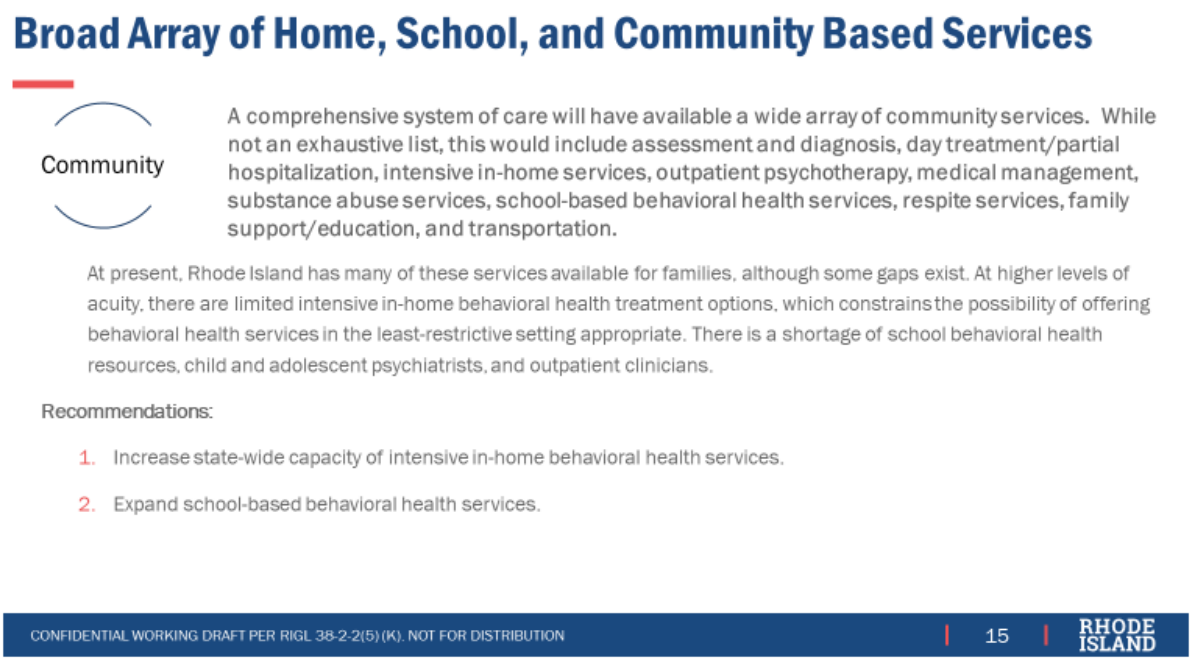
Next, with Community, you'll see an array of services – want to see an array that are culturally and linguistically competent. Probably some services that work – and some that are lacking.

Also, care coordination – in the state, we have the FCCPs and the MCO, and children's special health homes for children with special needs. Also, our need for mobile response and crisis services. (Planting some more seeds, for where we think there are gaps.)

And then looking on the list of most restrictive, there are things that exist – but a gap with adolescent substance use treatment.

What we are tasked with:

- Working on identifying gaps and how to move forward with a broad array of home, community-based and school-based services – as comprehensive as possible. From entry and assessment and identification of needs through services in schools and home (least restrictive) and then most restrictive.
- We have our fair share of these services, but they may need improvement – and where we don't have the services at all.
- We are charged with increasing our capacity of in-home BH services, and school-based BH services – at a minimum. This is not an exhaustive list.



Discussion:

Carlene Casciano-McCann: It's exciting to be a part of looking at the entire system of care. Looking at this and wondering where primary prevention fits into the service array. We're going to be identifying families at risk and where things have already happened. Where are things like family resource centers for the service array.

Jason: I'm so excited you brought that up right out of the gate. During the last meeting, I was wondering what folks meant by primary prevention. Do you have any other examples besides family resource centers?

Carlene: No other ideas, except things like Family Resource Centers. I'm wondering if there's a need. I think that Health Equity Zones are places that families can drop in. Supports and services that help struggling families, so they have the need to receive higher level services. In other areas of the country, they exist but not here.

Jason: Primary prevention struck a chord at the larger meeting. Does anyone else have ideas?

Carlene: Maybe Safe Care – working with moms and youth 0-5, helping families a little more at risk. There are models out there, and definitely something we as a state should look at.

Nidhi Turner: Related to primary prevention, one aspect is looking at intensive care coordinators strictly Medicaid funded. Don't need a diagnosis to get case management. They look at what the needs are and the resources they need. Empowering the families to get those services – and connecting them to what's available in the community. That model has worked really well, integrated with PCPs and schools. Reach out to your local community care agency. Helps to wade through all of the noise. You have your psychiatrist telling you one thing, service provider telling you another, a school telling you another. Family says: What am I supposed to do?

In terms of the service array, the thing that strikes me is the lack of intensive of clinical service in the home that are provided. Even with HBTS, PASS and others, there's not a model of intensive family therapy – family dynamics, sibling dynamics. None of the services in RI allow for that. Feels like a band-aid instead of sustainable change.

Dr. Flanagan: Also was going to bring up the notion of preventive mental health. Relational health and supporting early dyadic relationship are very important. Clinical or community setting can be helpful. I think everyone's familiar with ACES and fewer are familiar with Positive Childhood Experiences (PCEs) as moderating adverse ones.

Also, I second Nidhi's comment for family therapy. Working with the family system is really hard to find in RI in any of our systems right now.

Joe Robitaille, Trudeau Center: For prevention – I see it through a treatment model. Also, folks on the autism spectrum. HBTS, PASS, these services are mostly likely in conjunction with mental health are a beautiful model to have. What I keep thinking, though – we talk about a broad scope of services. We all come from a different perspectives. I think we should have a list of what's available. Look at it two different ways – what's available that needs some financial and fiscal support and what we can invent. We can then look: what's DCYF's role, for example.

And EI, is that in the scope for community, home-based programs? It would help us to understand what services we're talking about.

Jason: I'm not sure EI has been included as part of the BH system of care. Not sure we're purposefully omitting it. Do you think it's part of the preventive piece, or a part of learning?

Joe: Absolutely it's a preventive measure. 0-3, first encounters with professionals to guide their development. Prevention of more expensive care. Schools will benefit not having Talking prevention – absolutely right.

Margaret Holland McDuff: I would 100% agree as an early EI provider. We do assessments, SUD screening for parents. We do a lot of BH education around resiliency. We do need a full inventory of a service array, and the model programs out there that are out there. And through this process I want to make sure they are lifted up and looked at. We don't want to unintentionally make decisions that have some of those promising practices and those services go away.

Ben Lessing: I want to concur with what Margaret and Joe said. I also wanted to say that one of the obstacles around EI is that the federal standards are very narrow. They really focus on disability. And so, you can address developmental delays - but being in the homes, we see a lot of BH issues and with their parents as well. To do this, the state needs to weigh in some more having some BH supports.

It's up to individual programs as to whether they initiate those programs. Some will be very narrow on their diagnoses. Certainly a platform to be able to get there early and address BH issues as well.

Jason: The Faulkner Group has been doing an inventory of the BH adult and children System of Care in RI. They did a total inventory, and it sounds like that would be like the first draft will be hearing the ability to share. Having all of these things listed will be helpful.

Marti Rosenberg: Yes, the Faulkner Group talked to many organizations and community groups. There may certainly be things on the list that are missing – and so we will be soon releasing a draft so that people can comment.

Rosemary Reilly Chammat: On the prevention piece, I wanted to mention on the school end, multi-tiered systems of support. There are three tiers – with the work that RIDE's been leading with communities and the multi-tiered systems – social emotional skills are a critical piece on the prevention end. Even the funds we've been trying to bring into the framework are all within the multi-tiered system.

Margaret: I wanted to talk about primary prevention. Rosemary mentioned a lot of these. Co-located mental health services. Big Brothers, Boys and Girls, the Y – having robust group of clubs, including LGBTQ+. Those are all primary prevention, so that if they get to participate in those, they don't need to call FSRI to find what clinical

services we have. These are positive childhood experiences and building resiliency. Key strategy that we should remember during the survey of existing services as well.

Tara Hayes: Early BH supports – knowing that HBTS and all of those services in the Medicaid plans, and we're looking for what's happening for reprocurement. Important to talk with the plans on how they're covering the services. If they're being referred and they won't take it at face value, it's partnering with the clubs to make it be something to help the families.

Care Coordination work – there are so many pockets in which CC lives: Cedar, BH system. I know RIDOH has that in their Title5 work to work on this. We're going to do a survey with families with children with special needs. We're happy to share that information, to see where the gaps need to be filled.

Ben Lessing: 3 things:

1) Reintegrate intensive community-based services. Reinforce: these services need to be able to be delivered on a home-based way. When we've had these services, they'd been integrated with school systems, to work with schools to stabilize kids. From my point of view, this is something that could be done relative quickly, in terms of going to MCOs and undoing some of the things they've done called enhanced out-patient services. We don't have that foundation as the state. One of the things we see for kids being boarded in Eds. Kid not being able to be transitioned out of hospital programs.
2) Mobile crisis services – we effectively don't have those services. We need to reinstate this system for that to be able to happen. Needs to be 24/7. We have BH link for adults, but need mobile services and crisis help for kids
3) There has been a collapse of sustainable service -we need sustainable rates. And it needs to be connected to some level of case management, especially for high stress communities – Providence, Woonsocket, Central Falls, and Warwick. Places with a high level of issues of social determinants of health, need case management services and those aren't in place as well.

Becky Almeida: I want to thank Ben for his comments, because it touches on everything that affects my families.

I have a great team for my triplets and my 10-year-old that I adopted through DCYF. This week, my 10-year-old ended up in an ambulance to the hospital. There were 30 children waiting for psych bed at Hasbro, as well as multiple medical patients. Kids are put in the tiny room with no parents allowed in the room.

I also liken this to cancer – thank god my kids don't have cancer, but they have behavioral health needs. When you have cancer, the doctors don't say you're good enough for now and stop services. This approach with mental health leaves a lot of kids dangling in the wind. It's making parents need mental health services as well because it's burning us out.

I'm looking forward to getting my hands dirty to try to get things changed. We're tired. We're grateful – but we have to do more and have to do it immediately. Thank you for what you're doing. I really appreciate it as a mom.

Lee Robinson: I'm an MD at the Brown Center for Children and Families. Agree with what people have said – I'm relatively new to RI. Moving from primary prevention to acute care – here are things that haven't been mentioned so far:

- Supported youth summer employment options and summer camps. Secondary prevention – therapeutic after school space. Integrated care. Lot of state where the state has helped build infrastructure. Really good examples of that that RI can do more of.
- Diversionary programs for youth interacting with the criminal/legal/police systems. Creative partnerships between mental health supports and police departments.
- Acute care – mobile crisis is really invaluable. Without it, it's just emergency department care, and we've just heard what's that like. In some state, urgent care for youth. There is fear of Hasbro.

- Dashboard for the entire state like they have in MA. This allows people to look at wait times and availability.

Jason: Do you know if it's a private agency? Or state run

Lee: It's run out of Beacon.

Margaret: I'm interested in talking about models for working with police. Family Service is in 5 police departments now – including Providence Pawtucket, CF. We connect families every day to psych evals ourselves and mental health crisis evals, as well as connecting to services in their community. This is a key access point. There are other models too – Thundermist and others have them. That will continue to grow as police departments are evolving.

Jason: What could the state do quickly? If money weren't an issue – based on your knowledge and your awareness of the existing system of care. That folks could initiate soon or sooner or in the short term?

Ben: Intensive community-based services – we just need to deal with the managed care orgs. We know that kids are stacking up in Emergency Departments.

Jason: Why do you think that we don't have that right now?

Ben: Because the MCOs took the model that DCYF had created and turned it into an acute care model. Average length of stay for what became CIS was about 18-20 months – and it had flexible levels of care. Once those resources went to managed care, they turned it into an acute care model.

You have kids that get into crisis and they become stabilized. But many of the managed care orgs focus on symptom reduction, and bump to a lower level of care and the cycle starts again. Clinically, it's awful for kids and families, because the stabilization doesn't take place over a longer period time. Cycle continues in terms of crisis. Financially, it makes no sense for the state on the resource getting expended. Hospitals stays and residential expenditures.

Becky: What he just said – now it's the EOS (enhanced services). But is it really that enhanced when your kid comes out of a 24 hour facility and then it goes from 3 hours to 1.5 hours and the kids really only benefit from 20 minutes of services? All of my children have done at least 10-14 hospital admissions. They don't always get to benefit from the normal things kids can do. My eyes are filling up watching them right now in my driveway on their bikes. It's a little space of time where everything is OK. But you don't get a warning – and then full force boom and you're in crisis.

I had to call Tides because my daughter was that intense. I got voice mail and then got a person who then deployed an emergency team – but by the time she got there, it was too late and she needed the Emergency Department. It needs a step-down thing.

Maybe you get services, and maybe you don't. It's a balancing act for parents that we need to do as we still try to be able to be productive. I'm not just mom, I'm the psych person and the crisis person and the person for all of the other services. In the middle of the night, might I need to restrain them. Without supports in place, it will keep on flopping. It's very discouraging – you know it's not their fault. It's mental health needs. It's not about being a brat. That kind of stuff needs to get stepped up immediately. It's a waste of money to pour things into things that don't work. That's just me as a mom.

Do you know what's really sad? In the Emergency Department, when another kid says Hi to you. Hi Lucy's mom. We all know each other, because it's a cycle.
Jason: Thank you, we are here to hear.

Tara: These services are time limited. If the time needs to be extended – they need to be adjusted. We're supposed to be giving patient-centered care. Certain issues will keep arising.

Cheryl Dill:

- Dearth of home-based services in RI
- Barrier: staffing; there is a great demand for BH professionals in the state. Hard to find enough qualified clinicians to hire
- We could provide more intensive services in the home if we had the staff

Margaret:

- Quick change: Use the American recovery $$ to infuse the system and increase the wages for employees

Beth Bixby:

- We won't have access or capacity if the workforce isn't addressed
- Will send the Hassenfeld report on workforce challenges (https://hassenfeld.bryant.edu/wp-content/uploads/2020/08/HumanServicesFinal.pdf)

Rob LaRocco:

- Has worked in intensive home based services in RI and MA
- "Follow the money" – increase reimbursement rates, RI has worst rates in New England
    - Need to bring MCOs to the table
    - How can we sync up what's reimbursed and what's in the system of care?
    - If we don't get MCOs to support the system we create, they won't reimburse us.
    - Need to challenge MCOs as a state to ensure that they support the system
    - CBHI worked so well in MA that it reduced need for mobile crisis services

Joseph Robitaille:

- Need to map the scope of the systems, beyond Faulkner Report
- If we had workforce, staffing, reimbursement – would these systems be robust enough? What other MH programs are out there? We need to see the 'entire show' and then combine expertise to determine what requires more focus/$$
    - Visualize the system and then it will determine where the focus has to be, to lay the foundation and figure out where the needs are

Nidhi Turner:

- Immediate fix: increase amount of time that Master's level staff can interact with patients
    - Other states have higher level clinicians in the home, whereas in RI, it's mostly high school level workers
    - Have fewer layers of translation, since the main clinician is in the home and doing most of the direct service

Nidhi Turner email regarding co-chair

Thank you for the meeting today. I'm sure there are numerous volunteers, but I'd be happy to offer my assistance.