

**Children’s Behavioral Health System of Care – Data System Workgroup
Kickoff Meeting
May 10, 2021, 3 – 4:30pm**

Workgroup leads

Kim Paull, Executive Office of Health and Human Services
Annice Correia Gabel, Executive Office of Health and Human Services
Blythe Berger, Department of Health

Attendees

Alex Hunt, Tides Family Service
Ayelet Kantor, The Groden Network
Ben Weiner, Family Services of RI
Chris Strnad, Department of Children, Youth, and Families
Colleen Caron, Department of Children, Youth, and Families
Dr. Amy Goldberg, Hasbro Children’s Hospital and Brown University
Dr. Megan Ranney, Rhode Island Hospital and Brown University
Dr. Pat Flanagan, Hasbro Children’s Hospital and Brown University
Emily Corbett, Family Services of RI
Joe Robitaille, Trudeau Center
Liana Gonzales-McGee, Providence Public Schools
Lisa Conlan, Parent Support Network
Naiommy Baret, Parent Support Network
Natalie Fleming, RI Department of Education
Nicole Des Champs, Department of Children, Youth, and Families
Russ Cooney, Neighborhood Health Plan of RI
Suellen Rizzo, St. Mary’s Home for Children
Susan Lindberg, Department of Children, Youth, and Families
Tanja Kubas-Meyer, RI Coalition for Children and Families

Agenda

3:00 – 3:15: Introductions - What was your interest in joining this team? What do you hope to impact?
3:15 – 3:40: Overall System of Care Goals and Scope of the Data + Evaluation Workgroup
3:40 – 3:50: Ecosystem and APCD Overview
3:50 – 4:25: Laying the foundation for this group:
 What does success look like for the children’s system of care?
 Brainstorm: How will we measure success? [Early measure identification]
4:25 – 4:30: Closing Remarks + Next Steps

Acronyms

- BHSOC: Children’s Behavioral Health System of Care
- BH: Behavioral Health
- SPoA: Single Point of Access
- MRSS: Mobile Response and Stabilization Services
- CRP: Community Referral Platform

- BIPoC: Black, Indigenous, and People of Color
- SED: Serious Emotional Disturbance
- FEP: First Episode Psychosis
- SUD: Substance Use Disorder

Notes

Kim led review of BHSOC goals and activities

- Population of interest, initial geographic focus on Woonsocket and Providence, major grant activities (improved state governance, development of a single point of access, implementation of a mobile response and stabilization unit, and implementation of a community referral platform).

Initial responses

Dr. Megan Ranney

- The state lacks partial program services. It is often difficult to know what beds are available and where.
- Re: data collection, when people leave the ED, are they linked to services that are useful to them?
- Would be beneficial to learn more about protective factors, emphasizing prevention activities. Need for asset- or resilience-based longitudinal measures.
- The Emergency room shouldn't be the front door to our behavioral health system

Tanja Kubas-Meyer

- Raised least restrictive care options.
- Coalition convenes community-based service providers. Multiple proposals to the administration about intensive community-based treatment, and thoughts about capacity of therapeutic foster care to serve children in least restrictive environment. Hoping to see these represented in continuum of care being proposed.

Dr. Pat Flanagan

- Second interest to look at asset-building and resilience instead of waiting until crisis to intervene
- Equity in BH is very important, especially looking at data on language factors.
- Measure of continuity is important. Should be able to see how patients enter into higher/lower levels of care.
- Measures to capture flow through the system. Children stuck in high levels of intensity because we do not have the community-based care they need.

Joe Robitaille

- Clarity on the population of interest requested. Many children do not reach level of psychosis or SUD that may require hospitalization. Are we all encompassing children's BH or focused solely on SED, FEP, and SUD? Interest in prevention metrics in home-based services such as Early Intervention.

Dr. Amy Goldberg

- Need to highlight crisis that COVID has caused for children. FEP is a small number of children; SED is a growing population because of COVID alone.
- Will need to be mindful of transition back into school and offering support for children within school; support and guidance for teachers will be critical.
- Schools not necessarily included in community-based perspective on children's BH care.

Ben Weiner

- Providers are not adequately compensated to deliver the kind of care we're talking about here
- Many divergent data sources at play with children's mental healthcare. BHDDH collects deep data on services in their facilities but can miss out on private healthcare services.
- Raised issue of family consent with this level data collection, particularly for BIPOC communities.
 - o Specifically, can we collect consent at the single point of access?

Natalie Fleming

- School psychologists are not licensed; certified through DOH.

Natalie Fleming

- School psychologists are not licensed. School social workers have licenses but usually do not practice privately.
- Working to develop metrics at RIDE to count # children referred, # receiving services, # receiving services after referral.
- How coordinate with SPoA across multiple providers, and how can we identify students in need earlier?

Kim's response

- Regarding data consent: if we are doing this work well, the system is co-designed with the folks we intend to benefit.

Who else needs to be here?

- Rhode Island Student Assistance Services (RISAS) – Sarah Dinklage, Lee Raposa
- Parents
- Child outreach screeners
- Rhode Island Training School leadership
- Intensive service practitioners (inpatient and / or residential child psychiatric services)
 - o Kathleen Donise
- Outpatient clinical providers
- Home-based service providers
- Health Equity Zones (HEZ) focused on child mental health

Joe Robitaille – what services are available across the spectrum right now?

Annice provides overview of the Ecosystem: what we are, why we are, our race-explicit orientation, and the detail on the agencies and datasets available within the Ecosystem, pasted below.

What data are currently in the Ecosystem?

Kim:

- This data is all linked and trackable through time, so we can track families too, but it is anonymized and de-identified

Ben:

- Worried about insights we might gain, and what those insights might be without a person's consent
 - I.e. COVID data: being in foster care made a person more likely to get COVID. People received no benefit from participation in an EOHHS service, it's tricky to use their information to gain insights. We have a responsibility to think about how that info was obtained, and what our goal is as a state. It doesn't give us free reign to use this for research.

Kim:

- Explicitly—we do not look at individuals. We don't work with Ns<11. We've learned that it's important to be cautious. Want to make sure we're careful about what we look at and how we interpret the data. We now have a Performance Advisory Group, made up of outside people, who advise how to interpret the data.
- We want to improve our programs and use the data we have to do that, but how do we balance that? Something to make sure we consider throughout this process.

Commenter (no video or name):

- We know that children depend on parents. Do we have a way to link children to parents and siblings? To look at family-specific issues.

Annicc:

- Yes, some datasets where that is readily available, I.e. DHS benefits. It is complex to put families together on the data system.
- Could be a requirement of data we're requesting from vendors to be able to connect family units

Ben:

- How will this link to a system of care? You've implied that you won't look at the individual level, but how do you plan to integrate the Ecosystem into the system of care?

Kim:

- Yes, we are hoping to use data from a vendor to track the success of the system of care

Further discussion about ownership and guardianship of the data. Goal is to bring data into the Ecosystem to assess the effectiveness of this work. Data does not flow out. There is no release of data with any identifiers. Want to make sure that we think about ethical data ownership. Want to be intentional about consent. Will matter with vendors we work with as well.

What does Success look like and how will we measure it?

Need to ask the schools, parents; Schools have their own behavioral healthcare systems and procedures that are sometimes separate / self-contained from the non-school behavioral healthcare system

Success:

- Fewer:
 - Emergency room visits for kids for behavioral health needs

- Should be especially true for those who called the SPoA or were served by the MRSS
 - Psychiatric inpatient and/or residential stays
 - Readmissions and repeat ER visits
 - Improved
 - Parental functional status
 - Family satisfaction
 - Provider satisfaction
 - Match / completion rate of referred services
 - Kids in the correct setting of care
 - Standardized screening and assessment across providers

Additional Data / themes:

- Child outreach screening data may show early indicators of disruption and emerging behavioral health concerns for the child
- Evidence of upstream BH services and crisis prevention is much needed – both in our activities and our data / measurements

What do we intend to affect? What does success look like? What are initial metrics?

Susan Lindberg:

- At a higher level, the over utilization of EDs and high-end psychiatric hospitalizations will be reduced. We will know the outcomes of the MRSS services to see how family and child wellbeing.

Colleen Caron:

- Reduce rehospitalizations
- Look into educational outcomes
 - Be able to fulfill role as a child: doing well in school, peer relations, family functioning, etc.

Ayelet:

- We are showing most metrics about efficiency
- How can we capture quality of the services?

Natalie Fleming:

- How are we assessing? Are we assessing equally across providers, schools, families, etc.
- How can we come together as services providers so we're sharing the same definitions and measuring it consistently. Need to see each other as partners and not competitors.
- Common understanding across providers, consistent screening and assessment. So that everyone is recording the same thing.

Other metrics offered:

- Family satisfaction survey
- Provider satisfaction survey
- Make sure to connect metrics to the actual activities
 - Look at # of BH ED visits
 - Suicide attempts

- Rates of different kinds of involvement for BH needs (ED visits)
- Process metrics vs. Short/long term outcomes
- Monitoring of people being referred to the right agencies
 - How to initially assess needs and find right clinicians
 - Can we use this data to create policy where our reimbursement rates will be competitive with neighbor states
 - Can we investigate untapped resources – people who can potentially provide services in the community who aren't able to right now?
 - Increase pool of providers and better align people with services they need
- Add # of screenings to CRPP and # of referrals aligned to screenings to make sure appropriate referrals are being made
- How to connect outcome measure for SPoA? # of calls, how they're triaged, etc.
 - Make sure providers know to call this and access help in the community before calling the police
 - Would the SPoA just be for crises and for triage, or do we expand it more?
- Brainstorm metrics re: prevention
- Access to services prior to emergency event

Re: CRP:

- Service providers need to be confident in using these new platforms, need appropriate training to know what services are out there

How do we co-design solutions for impacting BIPOC community?

- I.e. Training school: kids there are punished for behaviors that might read as behavioral issues in other kids
- Have focus groups to look into this
- Look into schools for support and access to certain communities

Wrap Up:

- Thanks to everyone for joining the meeting.
- Grant decision is out in July – open to additional funding sources
- Community co-chairs opportunity
- Cadence: monthly?
 - Solicit information from group re: best time
 - Dependent on grant announcement