Meeting date, time and location: 06/14/2021, 3 - 4:30pm, Zoom

Meeting Facilitators/Presenters: Kim Paull, Annice Correia Gabel

Participants: Kim Paul (Director of Data and Analytics, EOHHS), Ben Weiner (Family Service of Rhode Island, Vice President of Administration), Maayan Rosenfield (EOHHS intern), Tanya Bernstein (Freedman HealthCare, Project Director for RI Ecosystem), Joe Robitaille (Trudeau Center - VP of Children's Services), Annice Correia Gabel (Deputy Director of Data + Analytics, EOHHS), Marty Sinnott (CEO at Child & Family), Alexandra Hunt (Clinical Director, Tides Family Services), Marti Rosenberg (EOHHS), Julie Richardson (school psychologist at Henry Barnard School), Susan Lindberg (DCYF, Associate Director Children's Behavioral Health), Nicole Des Champs (DCYF, Epidemiologist), Elizabeth Koonce (Freedman HealthCare, Project Manager for the RI Ecosystem), Deb Florio (EOHHS-Finance), Larome Myrick (DCYF Executive Director), Blythe Berger (RIODH Perinatal and Early childhood Health), Russ Cooney (Behavioral Health Project Specialist), Jess Lima (BCBSRI BH Clinical Program Specialist), Natalie Fleming (School Health Policy & Program Specialist-School-Based Mental Health-RI Dept. of Education), Naiommy Baret (Statewide Family Leadership Coordinator & Behavioral Health Educational Coordinator, Parent Support Network of RI), Jason Lanzillo (Frank Olean Center - Director of Children's Services), Don Laliberte (Director of Access at Bradley Hospital), Cris Almeida (Optum Provider Relations)

Discussion topic and facilitator	**Notes**

Review of last time and goals
 	
Facilitated by Kim Paull
	• 4 goals:
	  ○ 1) governance: new cross-agency work
	  ○ 2) SPoA: less emergency, more appropriate uses of SPoA
	  ○ 3) MRSS: fewer hospitalizations or residential stays, lower waiting lists
	  ○ 4) CRP: high and growing number of uses
	• Makes sure we have evaluations for each of these to help kids gain access to holistic and responsive care that prevents need for emergency visits later on, increase satisfaction
	• Key points from last month:
	  ○ Protective, strengths, resilience to build on what works
	  ○ Big focus on equity
	  ○ Continuity of care – what comes next after ED and how to make smoother
	  ○ Prevention and community-based care – make sure providers know what services exist and who refers
	  ○ Schools are key stakeholder that's a missing piece of the system
	  ○ Low provider rates
	  ○ Important to have consent around data collection – individual level data

How to measure success – what are metrics	See PowerPoint for more detail: • SPoA ○ # screenings

Facilitated by Kim Paull	○ Calls to SPoA ○ Family satisfaction ○ 911 behavioral health calls • Mobile Response and Stabilization (MRSS) ○ Youth suicide attempts ○ Family and provider satisfaction surveys ○ Consistent school attendance ○ Rate of restrictive use of care (IP, residential) for BH needs, including repeat visits ○ Waiting list size • Community Referral Platform (CRP) ○ # screenings aligned to referrals ○ # community services in the CRP Natalie Fleming: There are surveys evaluating student connection to school – can we apply here? Ayelet Kantor: Need to reflect fact that we have different needs for diff services depending on reason for call – eg drug abuse vs autism – want to make sure everyone is treated and getting services they need Kim: We need the services to exist from system development point, as data team need to make sure there's satisfaction Marti: we know there's gaps – maybe we measure size of gaps Ben Weiner: we do need to have different mobile responses for different crises and sometimes that's at tension with earlier stated goals about reducing ED visits. Maybe we can get at measuring this. Confounding factors – sending kids to ED/school attendance do not necessarily directly capture success of mobile response team, may reflect other things Kim: not all these metrics refer specifically to column but to overall whether system is working Susan Duffy: Hasboro ED physician – often end up in ED for safety reasons. Goal is assessing safety, many are referred, many are there because they can't access other care. What can we offer as crisis dissipates. We need to know what kind of services are available after. Kim: assessing safety – only can handle that level intensity and care in the ED right now. But think about is ED the only right place for this level of intensity in general. Susan: a good assessment of what are the gaps and services is necessary. Also culturally competent. Kim: important from SPoA and throughout. Larome, is there anything we're missing from the training perspective. Larome Myrick: culturally competent includes language. Important to make sure kids have insurance and instructions from how to take medication - is compliance possible? Susan Lindberg: add from NJ – fewer placement disruptions

	Blythe Berger: can people indicate that they wish they were able to make a referral to a service but can't find the right service? Marti: unite us is community referral platform so we need to see what they're able to do. We can talk with unite us about possibility Larome: not criminalizing youth behavior Susan: racial disparities in criminalization of behavior Kim: training school entrance rates and by race and ethnicity, what proportion at entrance had behavioral health crisis Natalie: documentation of how infractions are being coded in codes of conduct – think about the language being used to code behavioral health infractions and how we're responding. Sent link in chat to what is used when there is a behavioral health crisis Annice CG: Also imp: timeliness of mobile crisis team and community referral
Sources of data to collect and tap Facilitated by Annice Correia Gabel	New idea: stable qualitative data collection process – family satisfaction, etc. On annual basis. Who would we interview: people referred to MRSS who have been directly impacted by system. This is what we have for the grant and grant language purposes but we can also expand. ED claims data – establish baseline for how kids use ED room. Use all payer claims database (APCD). Want to know what that looks like on month to month or more frequent basis Susan Duffy: Have you considered interviewing comparison group of ppl who enter ED room and aren't accessing mobile crisis? Ayelet Kantor: People who go to ED are those who can't wait the 2 hours for mobile crisis team Ben Weiner: Could have Hasboro (or some ED) ask: did you know this existed, did you try calling Ayelet: are you thinking about criteria for when appropriate to call kidslink vs go to ED Susan Lindberg: try to operate like kidslink right now – triage on the spot and refer to appropriate referrals and services - 988 number Ayelet: there are other children with other needs that could be very intense but have nothing to do with suicide, must teach how to work with those families Annice: collect data for screening – SDoH screening, ACES screening, brief biopsychosocial, mental status Susan Lindberg: we're developing a single standardized screening Ayelet: do you also want to measure who could be out of ED but not adequate outpatient form Susan Lindberg: kids in hospital who could discharge but no place to discharge to, kids waiting for bed in Hasboro Susan Duffy: well often kids are admitted for inpatient because they meet the criteria not because there's no outpatient We also need to think about families not just the kids and the resources they need.

	Ben Weiner: For SDoH and ACE screening It's only useful if they have a pathway to respond and intervene – something to do with that information. Also you're asking the adults which could influence the responses you get. Natalie Fleming: how do we align with special ed services, assess if they're accessing adequate services for IEP, diagnosis. Care doesn't always align to need. Need to think about ongoing care after service. Ben: School attendance is protected under FERPA Susan Duffy: So much of the care kids get are from school so that's a really important piece Marti: CRPs are run by Medicaid AE's. Will be talking to Unite Us. Natalie: does this include providers in schools who bill Medicaid Ayelet: is goal to share data from school to provider or provider to school? Kim: both. Is system of care facilitating the connection? Can the student return to school after mobile health crisis. Ayelet: FERPA and HIPAA are different – police can see the data on substance abuse from school – nt shielded by FERPA Ben: May not be as good or accurate but can get around a lot of FERPA issues by surveying the students Chris Almeida: don't usually bill insurance for school MH Ben: we do, but we're talking more about school held data such as attendance, IEP, etc. Natalie: bill Medicaid for anyone who is licensed and then the school gets the reimbursement Susan Lindberg: schools bill Medicaid Natalie: or don't because it's such a process – administrative burden Annice: Utilization data tracking community referral program
Racial justice lens Facilitated by Kim Paull	Kim: need race explicit lens for everything, especially behavioral health, make sure each piece of project supports racial justice. Center in racial justice. Racism itself is public health crisis. Structural disparities plays a role in behavioral health consequences. Think about ppl of color often get more criminalized response. How do we also be very careful about consent, only collect data we need, and that products are all turned into reports.
Jamboard activity Full group activity facilitated by Kim Paull	Generate ideas for how to keep racial justice in mind in each step of data collection and use. Will bring together and collate and send out. What thoughts stuck with you: Nicole Des Champs: use existing data before inventing new data Kim Paull: saw one reflecting on the way people often don't trust the state's use of data. Consent for kids? Ben Weiner: hasn't been that long from state's abuses and causes of distrust (generationally) – how to not be in that dynamic

Chat	Susan Duffy to Everyone (3:22 PM) From the ED perspective need to be as concerned about behavioral dysregulation and aggression as suicide Natalie Fleming to Everyone (3:30 PM) RISAS was collecting the screening results from the Columbia-Suicide Severity Rating Scale and protective and risk factors survey as part of the RI Suicide Prevention Protocol pilot with Providence Public Schools...believe this screening tool is being utilized across schools and CBOs, etc. but unsure of where data/results are shared Natalie Fleming to Everyone (3:43 PM) RI Suicide Prevention Protocol: https://drive.google.com/file/d/1fL_h_rHgi8Ey28clsx_iEHNC7j16N1uu/view?usp=sharing Jamboard: https://jamboard.google.com/d/1tjpCU-AjKzl3qbvqcvggrH1TYfgS8LlwsF8JFXpedFI/viewer