Meeting date, time and location: 7.12.21, 3pm, videoconference

Meeting facilitators and presenters: Chris Strnad

Attendees: Maayan Rosenfield, Chris Strnad, Maria Terrero Kamara, Becky (parent), Kelci Conti, Marie Palumbo-Hayes, Jessica Walsh (BCBSRI), Laura Scussel, Robert LaRocco, N. Hermiz, Sarah, Robert Archer, Tanja Kubas-Meyer, Susan Lindberg (DCYF), Sandra Peltier, Jamie DiNunzio, Sarah Fleury

Review of last meeting	Chris Strnad	• Intro: talked last time a little about who should get ICC, let's drill down on that a little more. Then talk about pathways to access wraparound. Next will talk about metrics to know if programs were successful. • Summarize feedback from past meetings: System needs - centralized system and ability to access services, it's the primary way but not the only way bc no wrong door; want range of people involved including schools; critical workforce challenges; need to build natural supports who families trust; necessity for cultural and linguistic sensitivity; follow families' story all the way through, don't make families tell the same story repeatedly; what are critical elements of care coordination; housing theme from many of the workgroups; want to have crisis services available immediately and who can take referrals right away; provide training and support; focused on goals of family. • Who should access: families at crisis level, those for whom services are not working, anyone who wants care coordination services. • See more detailed notes on website or PowerPoint if your ideas are not reflected • Tanja Kubas-Meyer: it seems like we've broadened from CBH – what is this about? Just thinking about funding sources. • Chris Strnad: so this is a CBH program and we want to ground in that but intensive care related to that could include housing support, etc all these other factors that play into CBH. Speaking of this we need to narrow down. • Tanja: already have care coordination from MCOs and health insurance, different funding bucket if we take this too far. • Chris: This isn't clinical mobile response service, but a complement that thinks about broader needs. • Susan Lindberg: despite other care coordination out there, wraparound is critical for kids with the most needs (get multiple services), is the cornerstone of system of care • Rob LaRocco: If it is CBH, there should be some threshold needed like acknowledgeable diagnosis, etc. Just like any BH requirement in there for them to get services. Threshold to

		meet, look at child being client of that family. Billing goes through that child. • Chris: other care coordination works well but this is very specifically for families with most complex BH needs. For those really complex scenarios need more coordination.
Who should access service		• Chris: Thanks Rob for lead-in, we're looking for suggestions like that – who should access service? Not because we want to limit it. But because can't provide to everyone and have to have some prioritization. Are we looking for certain types of crises, should families have to access other services first? • Robert Archer: Child will have SED diagnosis. It would be helpful to know what whole population will look like. And then what % will need care coordination. Definitely kids in higher level of care or with higher level of care need. Not how much we do but how well treatment fits families. It's children at risk for higher level of care. • Chris: how would you want to identify that? • Robert Archer: Yes, we need some kind of standardized tool to assess that (CANS? Clinical assessment: at hospital or been to hospital) • Robert LaRocco: CANS – can use for child lens. But whether in crisis or not should still get this service. These services reduce hospitalizations. Must make sure can get services if not in crisis. • Chris: are there elements of the CANS we should focus on when finding a family who would be a good candidate for wraparound coordination? • Marie Palumbo-Hayes: can only get CANS if have a provider. Other assessments available if can see provider. But worried about people on long waitlists. We shouldn't just use police department or other services that only certain families will be involved with. • Chris: If a family comes in how would you decide whether to give them wraparound care or just lower level services?Marie: there are shorter faster evaluations than CANS that can do this. At risk to self or to placement those are the keys. • Rober LaRocco: Maybe that's where mobile crisis comes in. If can't get there in time, need to refer to elsewhere. • Marie: We can focus on levels of family stress rather than MH diagnosis (family stress index) • Tanja: Is care coordination different from wraparound services? I see that as different. • Chris: In the SAMHSA grant for SOC, wraparound facilitation put in as method to help families help themselves. Engage in family driven youth driven high fidelity process. • Tanja: so this is not looking at services? • Chris: no – another group looking at services.

		• Robert Archer: would distinguish care coordination and case management – it's a piece of wraparound, doesn't describe all of wraparound. A recognition that don't just want to pile on providers but wraparound tries to focus on the right fit rather than just more doctors. • Chris: Another element to identify is is it not just MH diagnosis, but it's really complex and what are all the complex solutions. Part of service is helping family find best way through complicated situation. • Robert Archer: individualized, what might work for one family doesn't work for another, look at barriers for families trying to get MH needs met • Susan: wraparound is also for kids involved in multiple systems not just with complex needs - pulls all of players together so everyone is working from same plan, same goal between eg juvenile justice, schools, etc • Marie: how does wraparound help in emergency crisis? • Jamie: need to have crisis plan in place in advance so know what to do in the case of the crisis – clear in advance what should happen in case of crisis • Kelci Conti: Must keep in mind really tough to develop plan in crisis – want to develop in advance or else just sticking on band-aid. • Chris: at it's best wraparound is distinct from mobile crisis response but operates with it fluidly • Becky: Utilizes mobile crisis frequently – answer can't be just call 911 and go to Hasbro. Hasbro gets overwhelmed and full. Difficult to sit there up to 15 hours for small psych eval and figure out childcare. Natural support and wraparound is great in theory but in action it's voicemail, leave a message, call this person and then why didn't you just call 911. That does not help her as a mom of 4 children with significant health needs. Grateful for the people who have helped but there has to be more than just call 911. • Susan: I agree with you but what you just described is what we're hoping to avoid. Goal is to have clinical people come to house within 2 hours and not have to go to Hasbro. • Becky: you have to understand how urgent this is and that 2 hours feels like 10 years. The other day Lucy (my daughter) locked herself in the house, beat up her sister, etc – have to understand the level of urgency. Even just waiting 15 min feels like forever. When my kid is having a crisis she can become aggressive and there are urgent needs so we need to be really sure that they come quickly
How should families access intensive		• Chris: want to allow families to access services through SPoA but many other avenues. What are we missing • Maria Terrero Kamara: PCP, afterschool programs

coordination and wraparound		• Robert LaRocco: In MA – website that identifies capacity that each agency has. Referral can come from anywhere - family can even refer themselves but then someone with independent license needs to verify and assess that person. All referrals should be good referrals as long as we meet qualifications for services. • Laura Scussel: Sees care coordination as families that have complex need that isn't being met (due to lack of insurance, needing something outside of box), the emergency is more about mobile crisis whereas this is about getting a family with complex needs being met to have group of ppl sit down and think about how to get them their needs. Do need a gatekeeper who's knowledgeable and can determine if this is something that's needed and that it's a thing that doesn't exist. At RIDE between referrals through roof and workforce challenges have waitlist for people with urgent needs. I see that as huge problem but separate from these cases with major complex needs. • Robert LaRocco: have we talked with anyone from MA who knows these services? • Chris: yes, have talked with some people recently in NJ and also in the past with MA, but important to keep in mind. • Becky: Follow model from Burrillville where there's this profile of what kids need, when crisis happens – would be great to have some kind of database that has needs identified by children. Need responders to have info ahead of time so that they're prepared when possible. Came up with idea to create care packages for people who go through ED with phone numbers, notebook and pen, etc – very scary as parent in that moment and helpful to have that reassurance as a parent. Now this is happening at lifespan and Hasbro
Outcomes measuring		• Chris: There has been evidence from research that high fidelity wraparound has high level of success in terms of school attendance rates, eloping rates, etc. See powerpoint, but there's a list of FCCP performance measures. So really quickly how can we know if wraparound is successful? • Robert LaRocco: lack of hospitalizations? Robert Archer: Kid in community? • Robert LaRocco: look at improvement in CANS domain • Maria: hear from families if they think service is working • Jessica Walsh: Also ED visits (don't always end up in hospital) • Marie: how many families call for services and become engaged in wraparound • Chris: what about addressing racial and ethnic disparities? • Tanja: assuming we believe not all families equally feel comfortable accessing BH services, need to think about how BH services are modified to meet needs of families. We know

		we have very few clinicians of color, traditional BH services might be unwelcoming or intimidating, families are overserved in some ways. Just need more input at family's level. Sometimes having more ppl coordinating your care is just exhausting and you don't want it. Must be very careful designing services for people who don't want input. • Chris: want to design services not overwhelming families, but following family needs. • Tanja: also think about history in child health that must be addressed. • Jessica: also track whether treatment workforce is racially and ethnically mirroring communities • Robert Archer: do do some measuring in terms of juvenile justice – how are CBH responded to in terms of race and ethnicity and punishment vs treatment • Chris: keep thinking about this, will come up in next workgroup. Keep thinking about process measures and outcomes.
Chat		• Maayan: Do we want to limit qualifications to based on MH severity or also think about language barriers or housing status, etc that could also make them good candidates for care coordination. • Becky's iPhone to Everyone (3:44 PM): We have to call kidslink which usually isnt very helpful • Sandra Peltier to Everyone (3:49 PM): I have had parents report the same thing, Becky. • Jessica Walsh, BCBSRI to Everyone (3:56 PM): ER Utilization • Robert LaRocco to Everyone (3:57 PM): hey gotta go...thank you all • Maayan: Number of languages services are provided in compared to languages in community