Children's Behavioral Health System of Care

Data + Evaluation Team | July 26, 2021

AGENDA

- 12:00 – 12:10: Warmup + Catchup
  - Add to the chat: Name / Org / What was the first vehicle you ever drove?
  - Review key points from 6/14 meeting
- 12:10 – 12:50: Review, Edit, Prioritize: Outcome and Process metrics
- 1:50 – 1:25: Review findings and implications of the baseline analysis of children's BH need
- 1:25 – 1:30: Housekeeping + next steps
  - Monthly 3rd Monday 3-4:30?
  - Planning team: 4th Monday 3-4:30?
  - Next meeting content:
    - Proposed analytic plan for the evaluation strategy | Data sources for key metrics | Refreshed baseline claims data

Review key points from 6/14 meeting

CHILDREN'S BEHAVIORAL HEALTH IN RHODE ISLAND TODAY

Lack of Clarity for Parents

Navigating the children's behavioral healthcare system in Rhode Island can be daunting, particularly when a child experiences a behavioral health crisis, especially for families of color. Parents may not know what to do, or who is available to help meet their child's needs in a culturally and linguistically competent manner.

Lack of Alignment within the System

Our current system is siloed. Responsibility for children's behavioral health services is fragmented across different state agencies. This makes it difficult for the system to deliver effective behavioral healthcare to all of our children and families in Rhode Island.

Need for a More Organized System

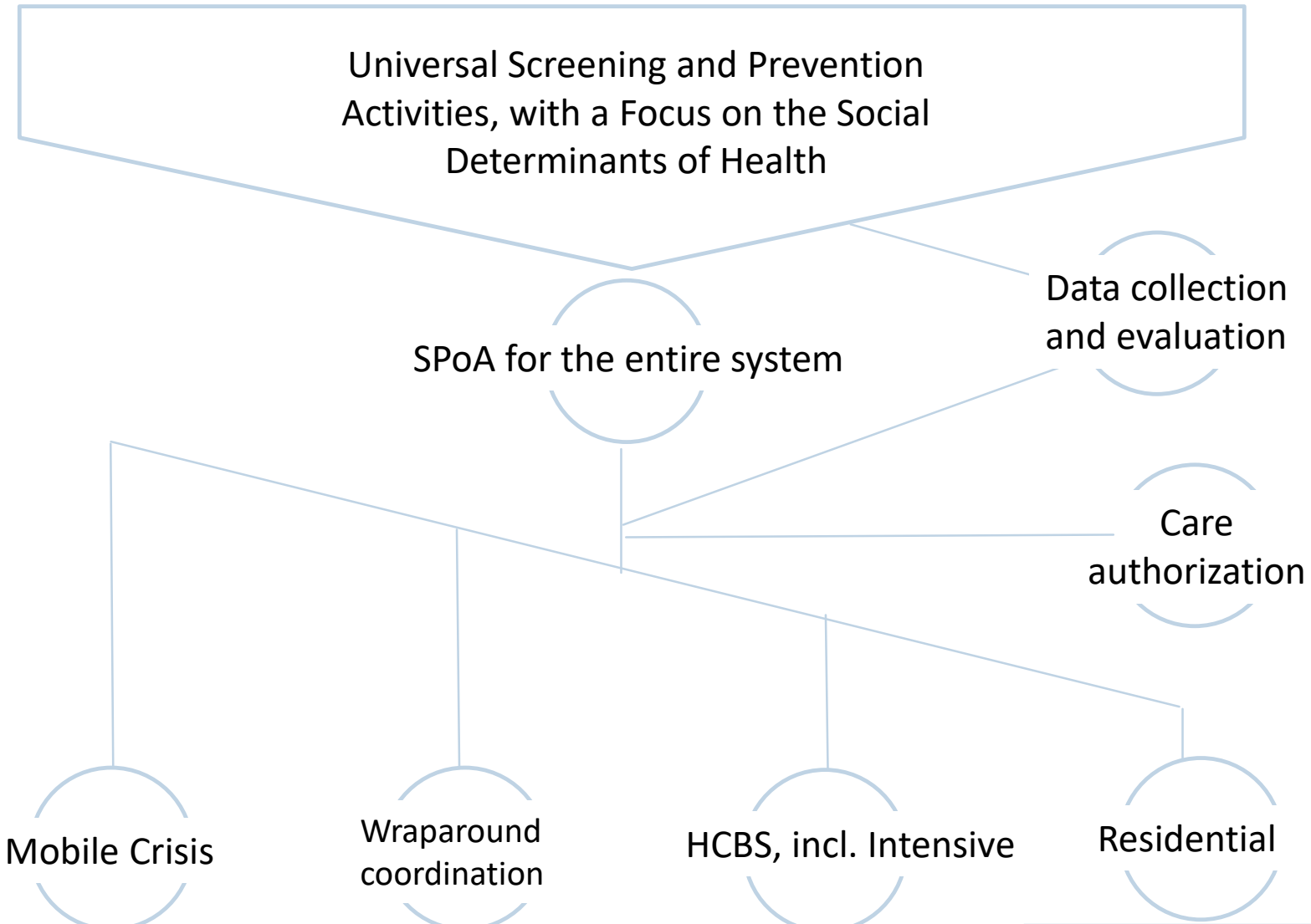
Rhode Island needs an integrated, culturally and linguistically competent continuum of behavioral health care for **all** children in the state that will provide an organized pathway to services and supports, in contrast to the multiple, typically confusing paths that are in existence today.

Overarching
System of Care

Our stakeholders' strongest suggestion is that our System of Care begin with prevention – so that it is not just a crisis system.

The Single Point of Access, with No Wrong Door, must be to the whole system.

The System of Care must be grounded by a Race Equity Lens, significant investments in the Rhode island Workforce, and in Community and Family engagement. We must pursue a sustainable funding structure.



Ensuring Racial Equity & Eliminating Disparities

Significant Investment in Workforce Transformation

Strong Community Outreach & Family Engagement

Sustainable & Braided Funding

What do we intend to affect with this System of Care? What are our expected data sources?

If the RISCOC is successful in its first set of implementation, we will see:

1. Governance: New cross-agency workflows and points of accountability; Pub/pvt SteerCo
2. SPoA: fewer calls for emergency dispatch; Growing, appropriate, and high satisfaction use of the SPoA
3. MRSS: Fewer hospitalizations and res. treatment stays; Lower waiting lists
4. CRP: High and growing use; growing # of providers

Expected Data Sources

- **Claims**: All Payer Claims Database (APCD) + Medicaid claims data
- **Ecosystem**: Linked administrative data, including
  - Medicaid claims data
  - DCYF foster care case management data
  - Department of Labor and Training wage or income assistance data
  - Homeless Management Information System data
  - Department of Human Services benefit eligibility and enrollment data
  - Department of Health birth and deaths; child screening, immunization and outreach data
- **SPoA vendor**: call volume with caller demographics and need type; trainings
  - Department of Health and/or E911: calls for youth in BH crisis
- **MRSS vendor:** call volume from the SPoA; GPRA perceptions of care; Family Workgroup focus group and satisfaction survey
- **CRP vendor:** linked community services, trainings, completed referrals, provider use of the platform

KEY POINTS FROM 6/14 (NOTES)

Key resources:

- *Website for Children's Behavioral Healthcare System*
- *Notes from 6/14*
- *Jamboard on Racial Justice in our Eval*
- *RISPA Suicide Prevention Protocol*

- Suicidality is increasing / kids are in ED for safety reasons
- Cultural competency (especially language) in services is essential
- Racial disparities may result from disparities in criminalization of BH-related occurrences and needs
- Social determinants of health (SDoHs) and Adverse Childhood Experiences (ACE) screenings are essential – and so is having the ability to respond to results (addressing need for child and family)
- Voices from school community are essential and often not connected to medical system

How will we measure success?
OUTCOMES METRICS

All metrics will be tracked by race, ethnicity, gender, age group

Overall BH Well-Being	Racial Equity: Close gaps in…	Least restrictive care	System Capacity	Satisfaction
Suicide attempts, ideation	School attendance	BH-related ED visits	ED visit length of stay	Family satisfaction with SPoA
BH-related IP admissions	BH crisis incidence	Rate of repeat ED visits	BH Inpatient occupancy / waiting list	Family and provider satisfaction surveys
MH + SUD Diag rates	BH-related ED visits	BH-related residential care admissions	Waiting list size for community providers	
School attendance	Calls to DCYF for BH support	Calls to 911 for kids in BH Crisis		
BH-related ED visits	Calls to 911 for BH support	Calls to DCYF for kids in BH crisis		
	Training school entrance	Training school entrance with BH crisis		
		Costs related to BH care		
		Foster care entry rates for BH		

Are we missing any important outcomes for the kids you work with and/or serve?

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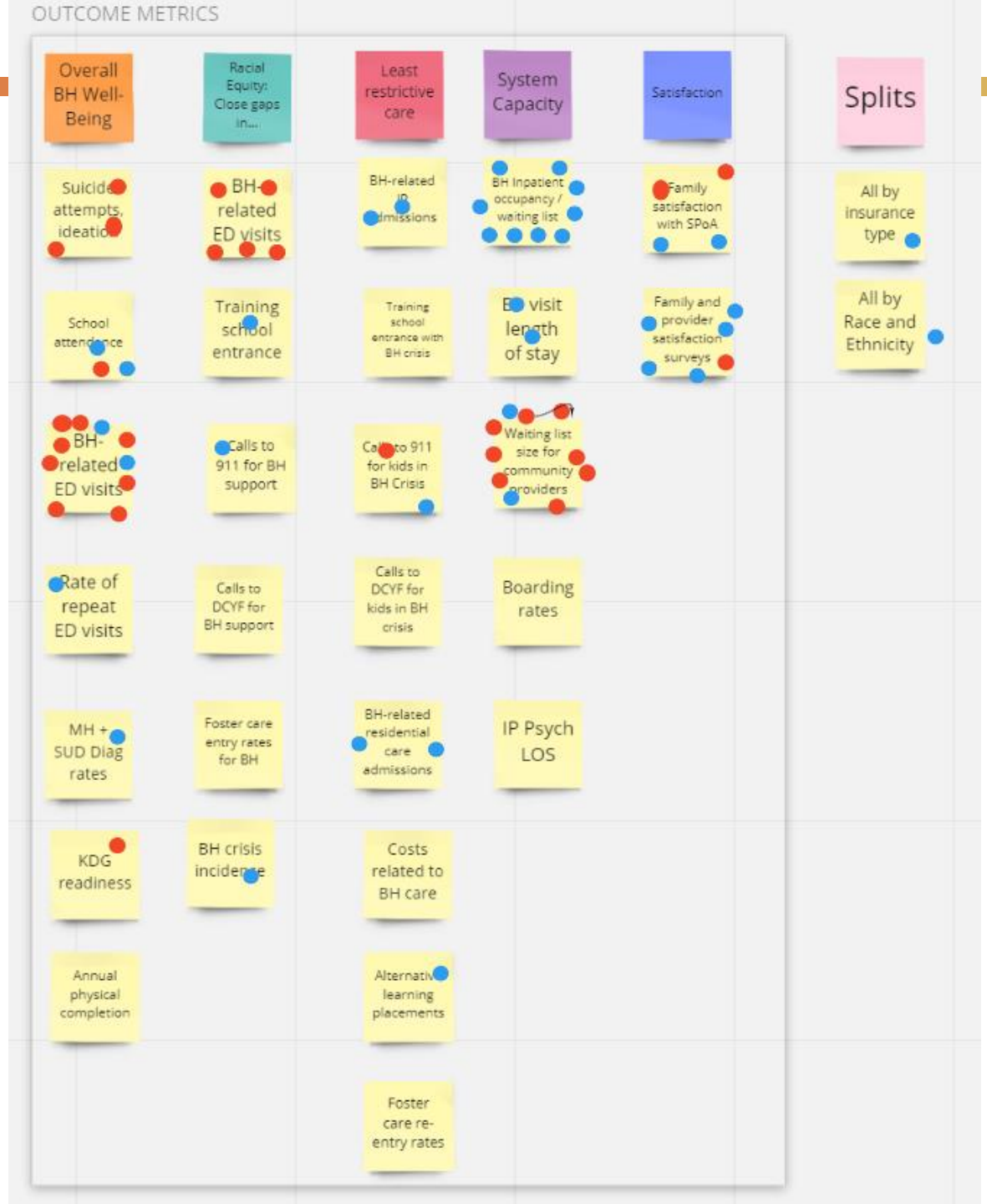
https://miro.com/app/board/o9J_l57qtCU=/

Metric	Top (Red)	Second (Blue)
BH-related ED visits	12	2
Waiting list size for community providers	8	2
Suicide attempts/ideation	3	
Family and Provider Satisfaction	1	5
School Attendance	1	2
Kindergarten Readiness	1	
BH Inpatient Occupancy / waiting list		9
BH visit length of stay		2
BH-related residential care admissions		2
BH-related inpatient admissions		2
Rate or repeat ED visits		1
MH/SUD diag rates		1
Training school entrance		1
Calls to 911 for BH support	1	1
BH Crisis incidence		1
Alternative learning placements		1



Red Dots:
Participants could place up to 2 red dots on measures they considered the most important indicators that *must* change to indicate CBHSOC success.

Blue Dots:
Participants could place up to 3 blue dots on metrics that were important to track and *will likely* move if we are successful.

How will we measure success?
PROCESS METRICS

All metrics will be tracked by race, ethnicity, gender, age group

Connection / Governance	Single Point of Access	MRSS	Community Referral
# SPoA handoffs to MRSS	# calls to SPoA	DCYF: Fewer Placement Disruptions	# Community services in the CRP
# MRSS handoff to CRP	# screenings completed [ACE, SDoH, SBIRT]	Home-based and telehealth care for BH	# of providers who use the platform
# CRP completed handoffs to providers	# calls to emergency dispatch by SPoA		# referrals
# school-based staff calls to SPoA			# completed referrals
# school-based staff logins to CRP			# of screenings aligned to referrals
Student-school connection survey (RISPA)			# multilingual providers
TBD Connection among agencies			
TBD Connection from providers to schools			

Are we missing any important outcomes for the kids you work with and/or serve?

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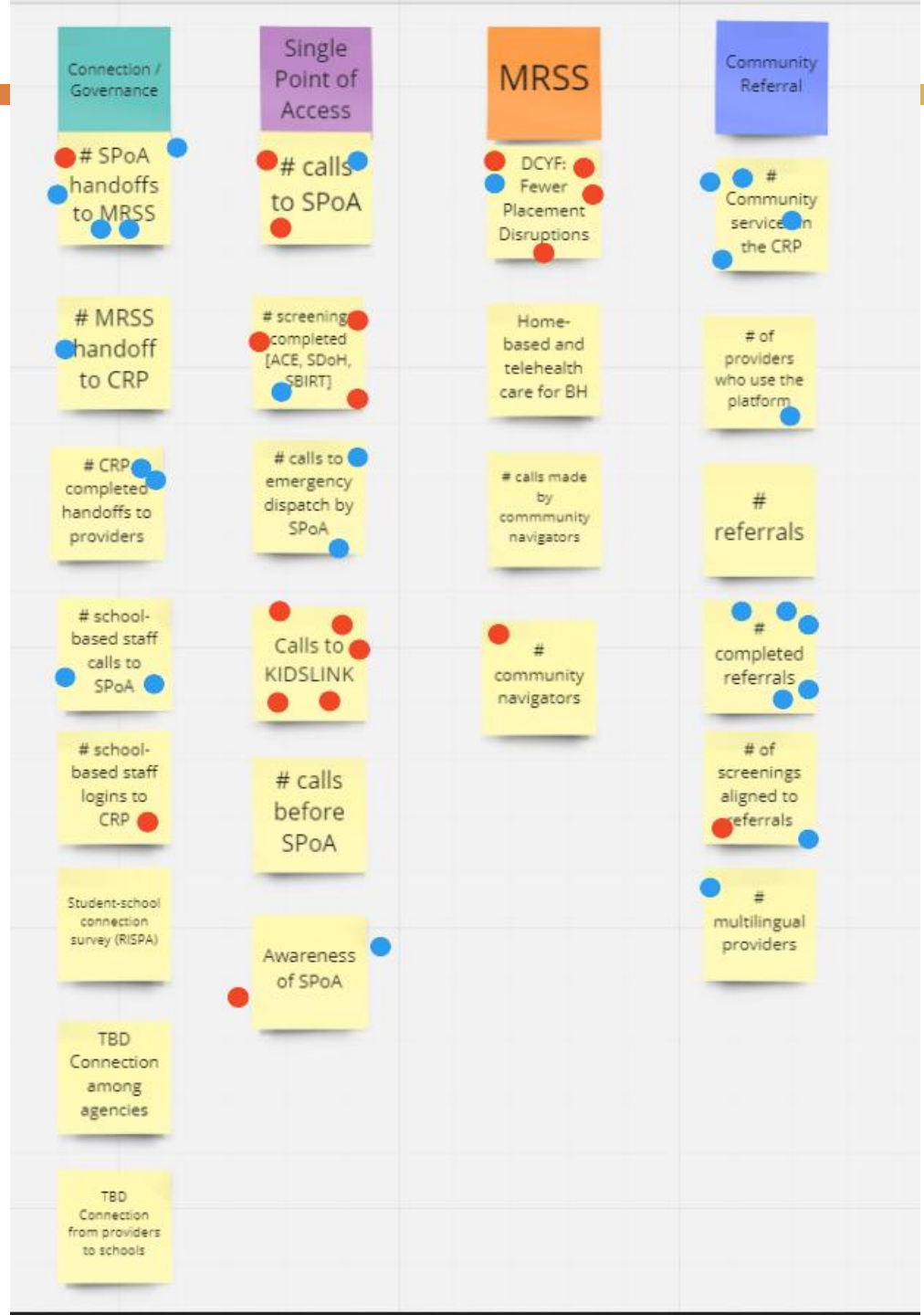
Metric	Top (Red)	Second (Blue)
Calls to KIDSLINK	5	
DCYF – fewer placement disruptions	4	1
# screenings completed	3	1
# calls to SPoA	2	1
# SPoA handoffs to MRSS	1	
# school-based staff logins to CRP	1	
Awareness of SPoA	1	1
# community navigators	1	
# of screenings aligned to referrals	1	1
# completed referrals		5
# community services on the CRP		4
# CRP completed handoffs to providers		2
# school-based staff calls to SPoA		2
# calls to emergency dispatch by SPoA		2
# providers who use the platform		1
# multilingual providers		1



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Overview of Baseline data: Children's BH Needs

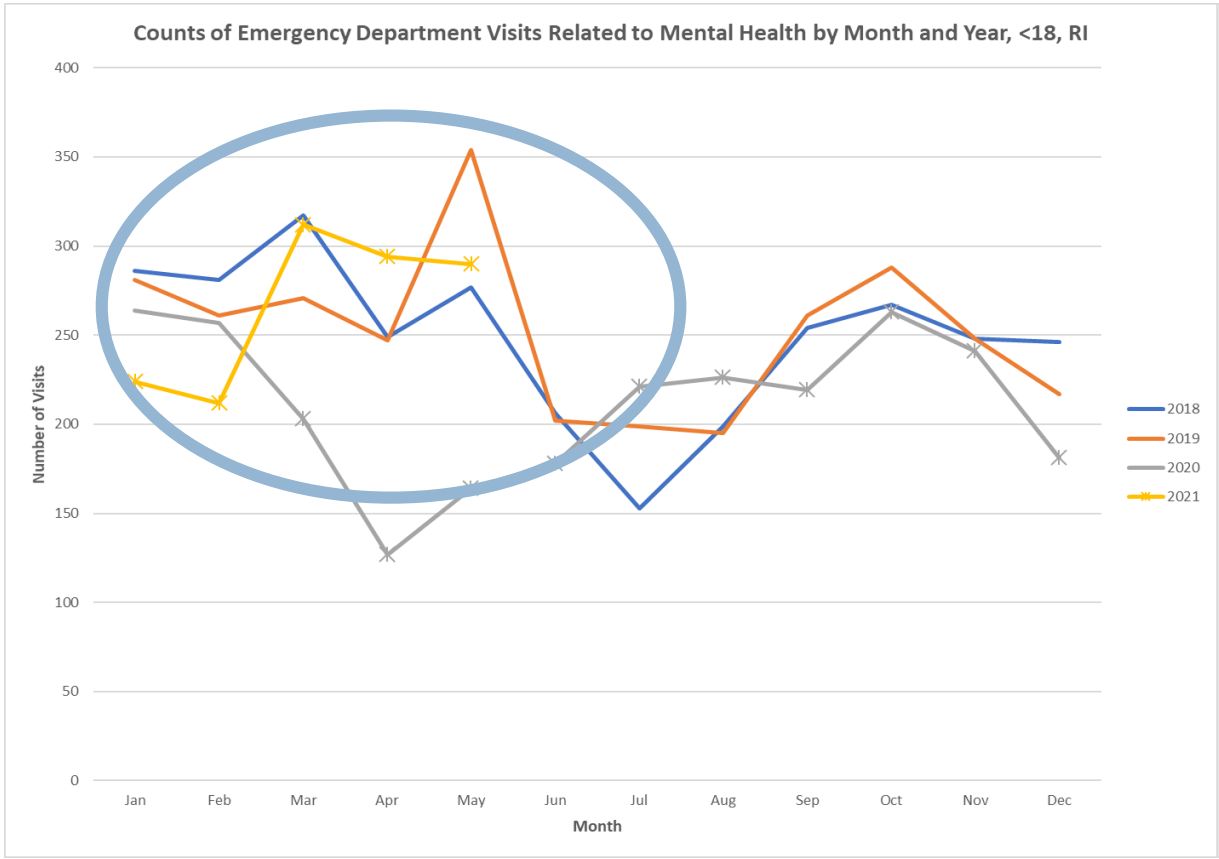
RISING YOUTH BEHAVIORAL HEALTH CONCERNS—NATIONALLY

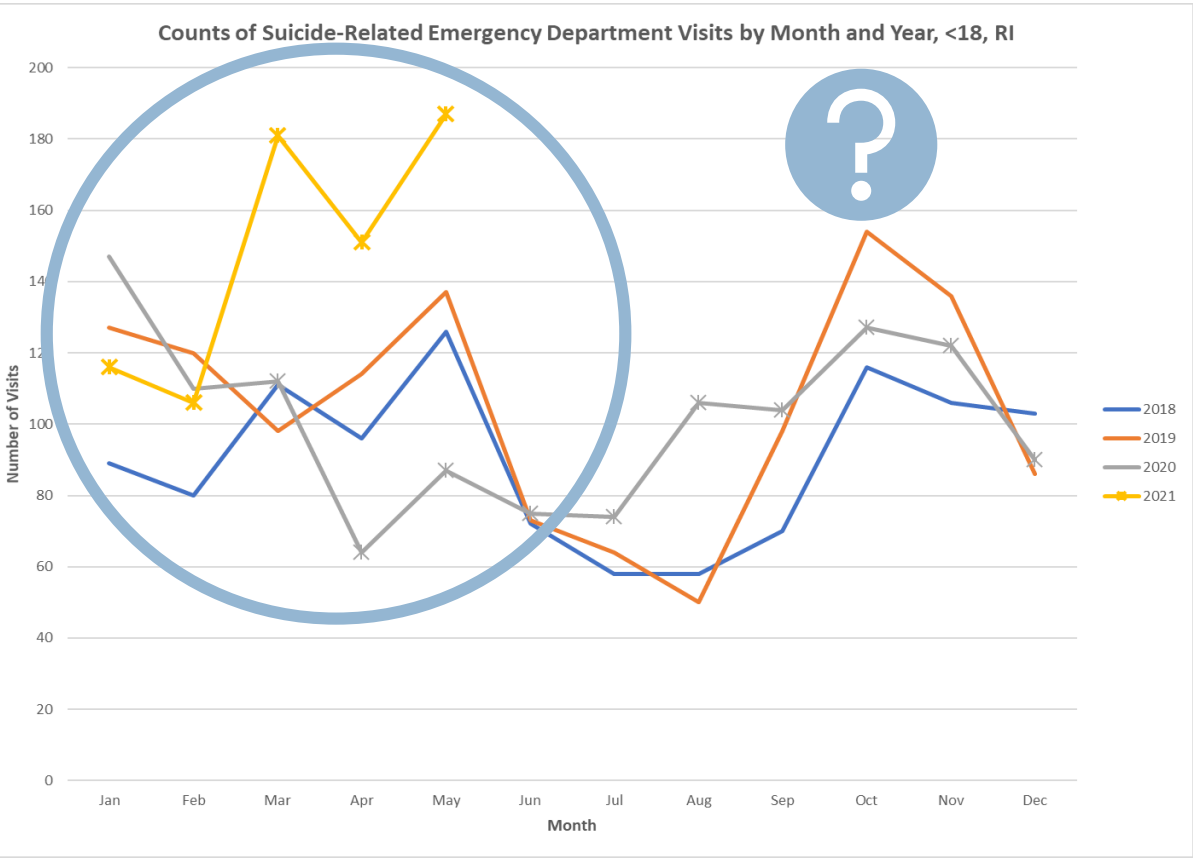
- **+74%:** increase in depression for children ages 12-17 from 2004 to 2019 data^
  - Adolescent girls are over 2x as likely to have an episode of major depression
  - Mental health emergency department visits increased 24% for children ages 5-11 and 31% for adolescents ages 12-17 between mid-March and October 2020 compared to the same time period during 2019

- *Morbidity and Mortality Weekly Report*, June 11, 2021: increase in emergency visits for suspected suicide attempts among youth.
  - By **May 2020**, Emergency Department visits for suspected suicide attempts began increasing among adolescents aged 12-17 years—**particularly among females**.
  - The weekly mean number of these visits in this population of females from **February through March 2021 was 50.6% higher** than during the same period a year earlier.
  - The proportion of **mental health-related emergency visits** among all adolescents aged 12-17 years **increased 31% in 2020** compared to the same time period in 2019.

^National Institute for Health Care Management

In Rhode Island: Concerning Rise of Suicide-related ED Visits in Spring 2021 Timed with School Opening





Increases in Hasbro ED Visits by Diagnosis

Orange text represents statistically significant change

Diagnosis Code	2018-2019 Average	2020 Actual	% Increase
Other long term (current) drug therapy (Z79.899)	348	374	7.5%
Personal history of self-harm (Z91.5)	155	262	69.0%
Suicidal ideations (R45.851)	159	231	45.3%
Parent-biological child conflict (Z62.820)	118	155	31.4%
Major depressive disorder, recurrent severe without psychotic features (F33.2)	100	151	51.0%
Disruptive mood dysregulation disorder (F34.81)	88	112	27.3%
Insomnia, unspecified (G47.00)	47	70	48.9%
Major depressive disorder, single episode, severe without psychotic features (F32.2)	38	60	57.9%
Personal history of neglect in childhood (Z62.812)	20	39	95.0%
Constipation (K59.00)	10	22	120.0%
Gender Identity Disorder (F64.9)	7	16	128.6%

Data provided by Lifespan on 6/16/21.
Comparison: Hasbro emergency department visits during the COVID period (757 total visits) to the average of 2018-2019 (789 average visits)

What do our Data Show about Broader Mental Health Trends?

- Source: All Payer Claims Database (Medicaid, Commercial, Medicare)
- Dates: Jan 2016 – Dec. 2020
  - Medicaid only, with more recent data, to follow in the next months
- Caveats:
  - Due to claims runout, November and December data are not yet complete
  - We are missing significant commercial self-insured data, particularly from United Healthcare

Our data show that each year since 2016, more kids receive a mental health or substance use diagnosis than the year before – especially:

- Adolescent girls (diagnoses among males *fell)*
- Commercial population
- Inpatient setting (with some increases in the ED)
- Accelerating in pre-COVID late 2019 into 2020

Caveats: *These data do not cover the 2021 trends – we'll have those updates within the next 1-2 months. Also, the findings are not meant to suggest that Males or those with Medicaid are not affected. It is possible that these groups are unable, unwilling, or otherwise hindered from seeking MHSUD care.*

Consider:

How does this rising need compare to our service offerings, capabilities (workforce), and capacity?

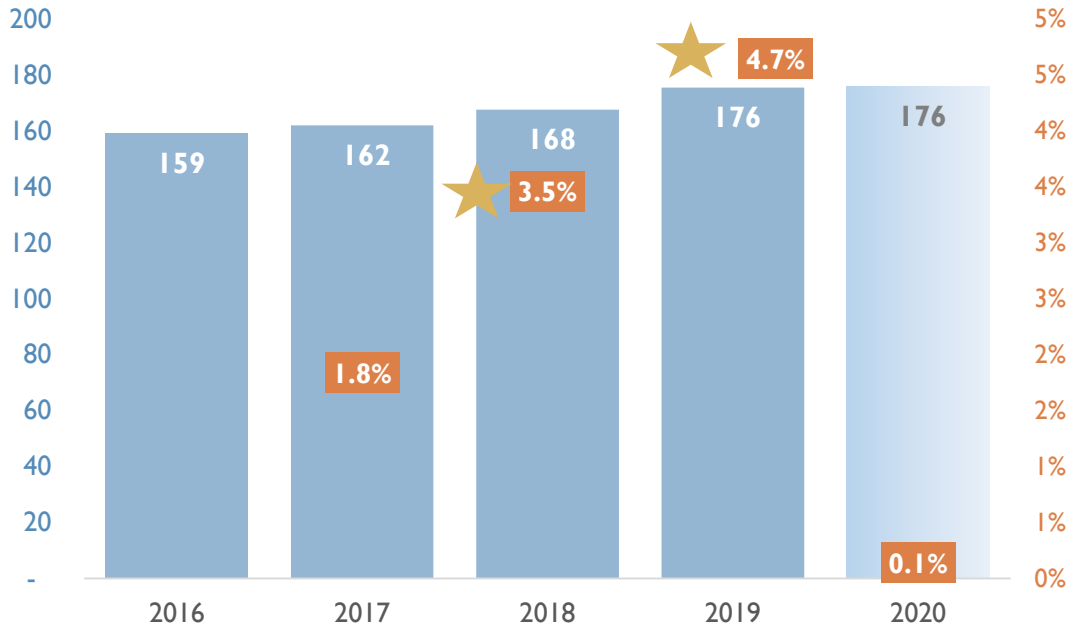
How could the System of Care address some of these findings?

THE NUMBER OF CHILDREN WITH MH OR SUD DIAGNOSES HAS BEEN RISING SINCE 2016 – AND ACCELERATED IN LATE 2019

★ *Statistically significant change from prior year ($p < 0.05$)*

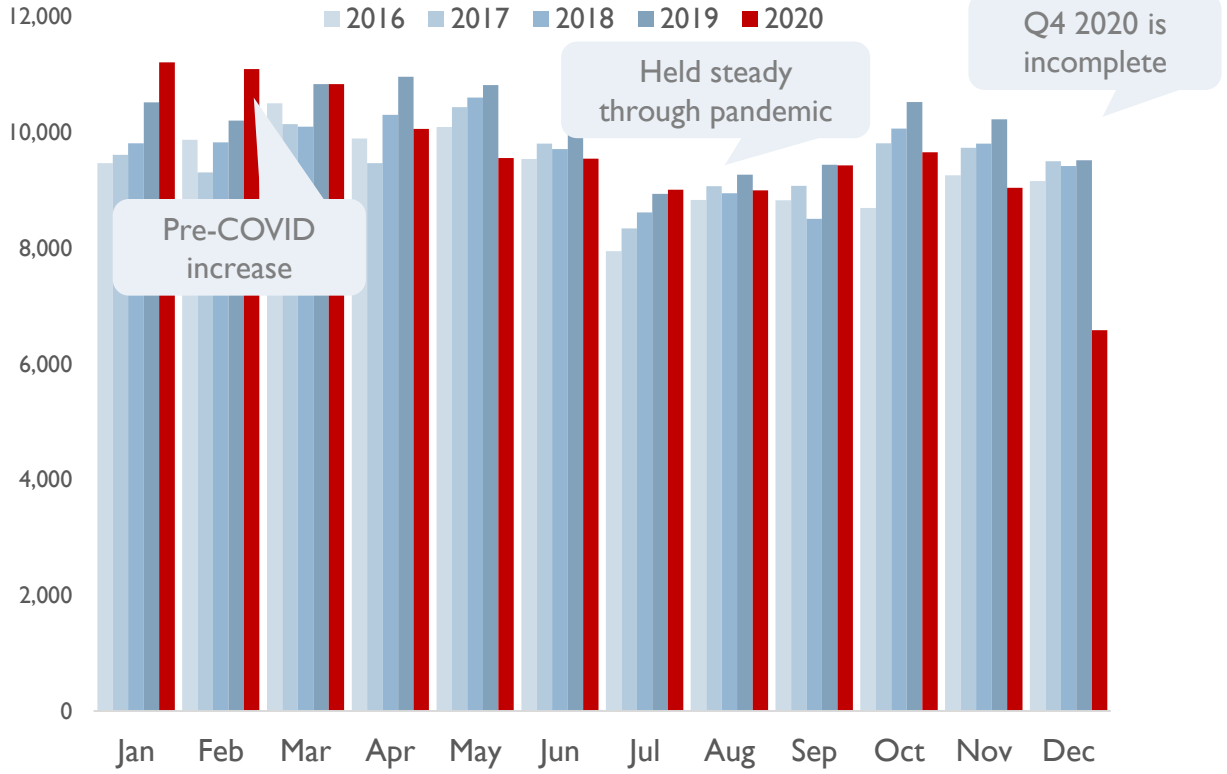
Rate for Selected Diagnosis per 1,000 Kids in Selected Population

Diag: Any MH/SUD | Age: All | Gender: Any | Payer: Any



Counts of Kids with Selected Diagnosis

Diag: Any MH/SUD | Age: All | Gender: Any | Payer: Any

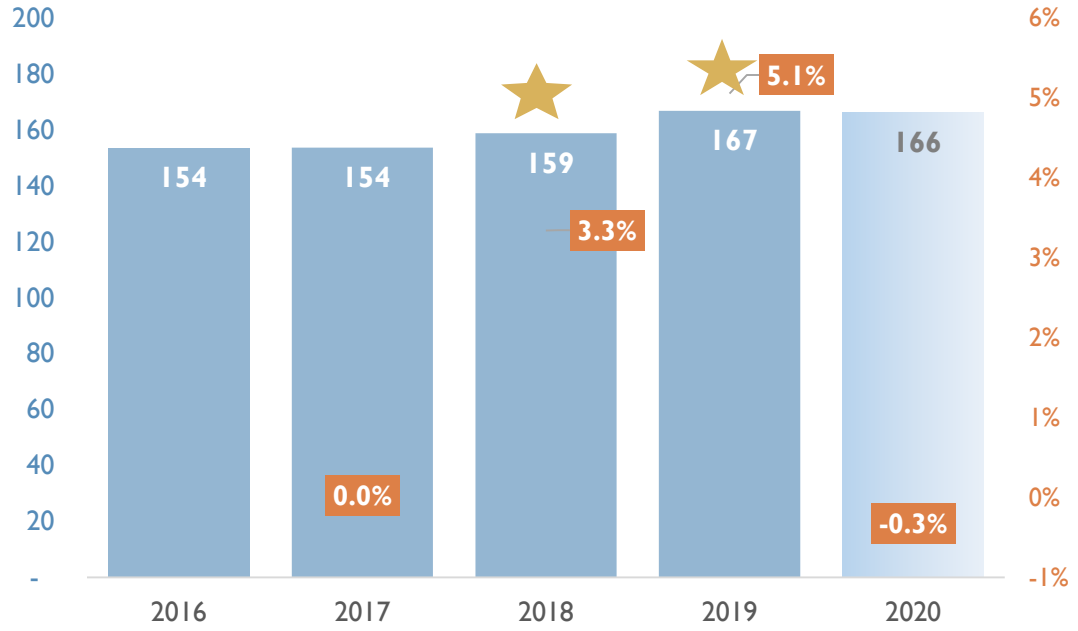


Overall rates of MH/SUD Diagnoses are higher in the **Commercial** population than the Medicaid population

★ *Statistically significant change from prior year ($p < 0.05$)*

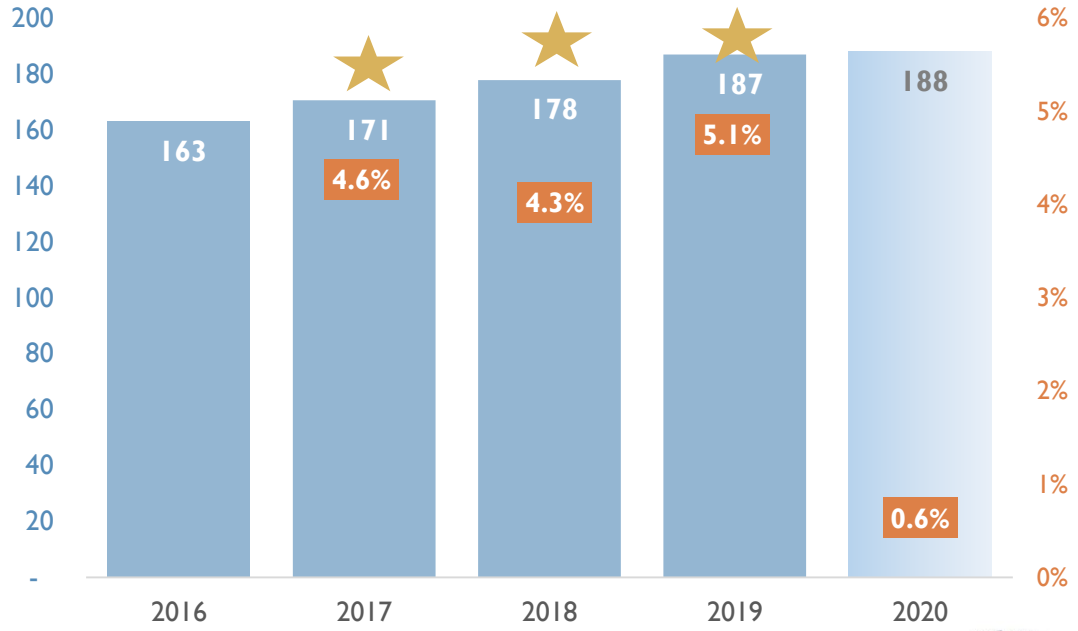
Rate for Selected Diagnosis per 1,000 Kids in Selected Population

Diag: Any MH/SUD | Age: All | Gender: Any | Payer: Medicaid



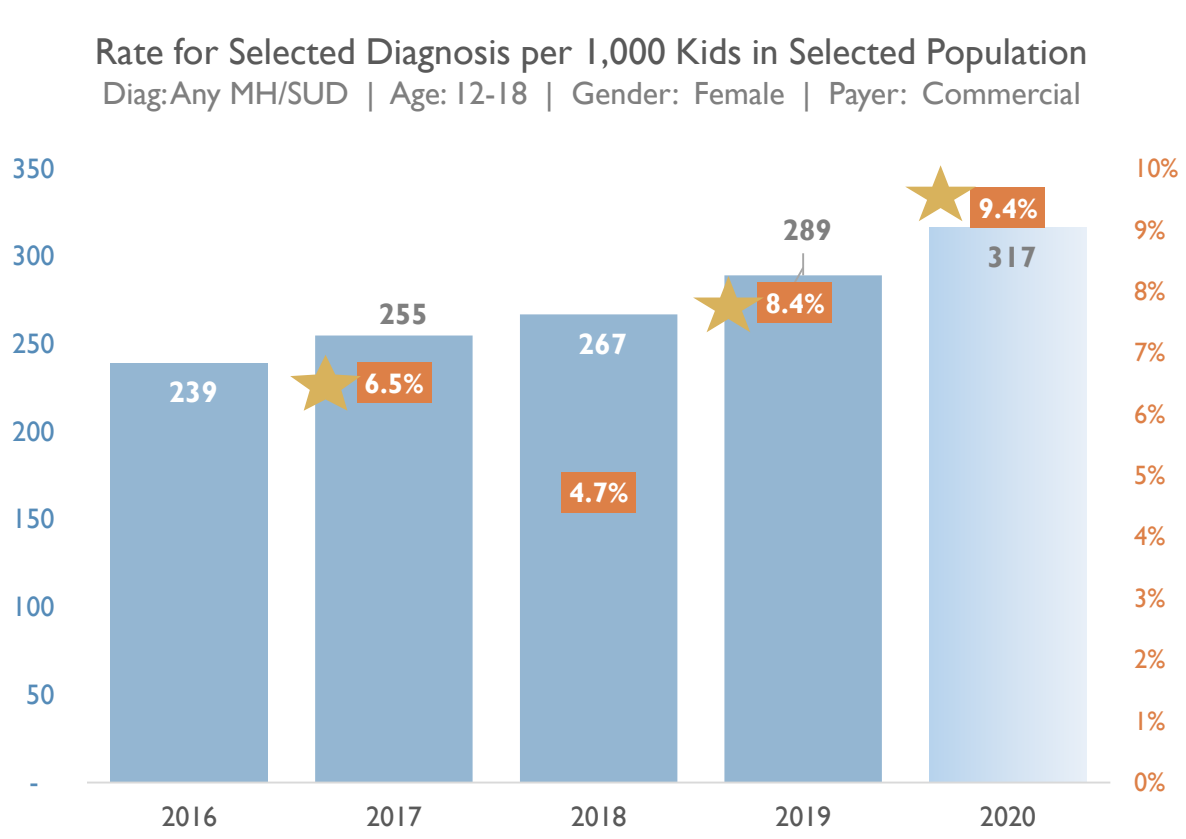
Rate for Selected Diagnosis per 1,000 Kids in Selected Population

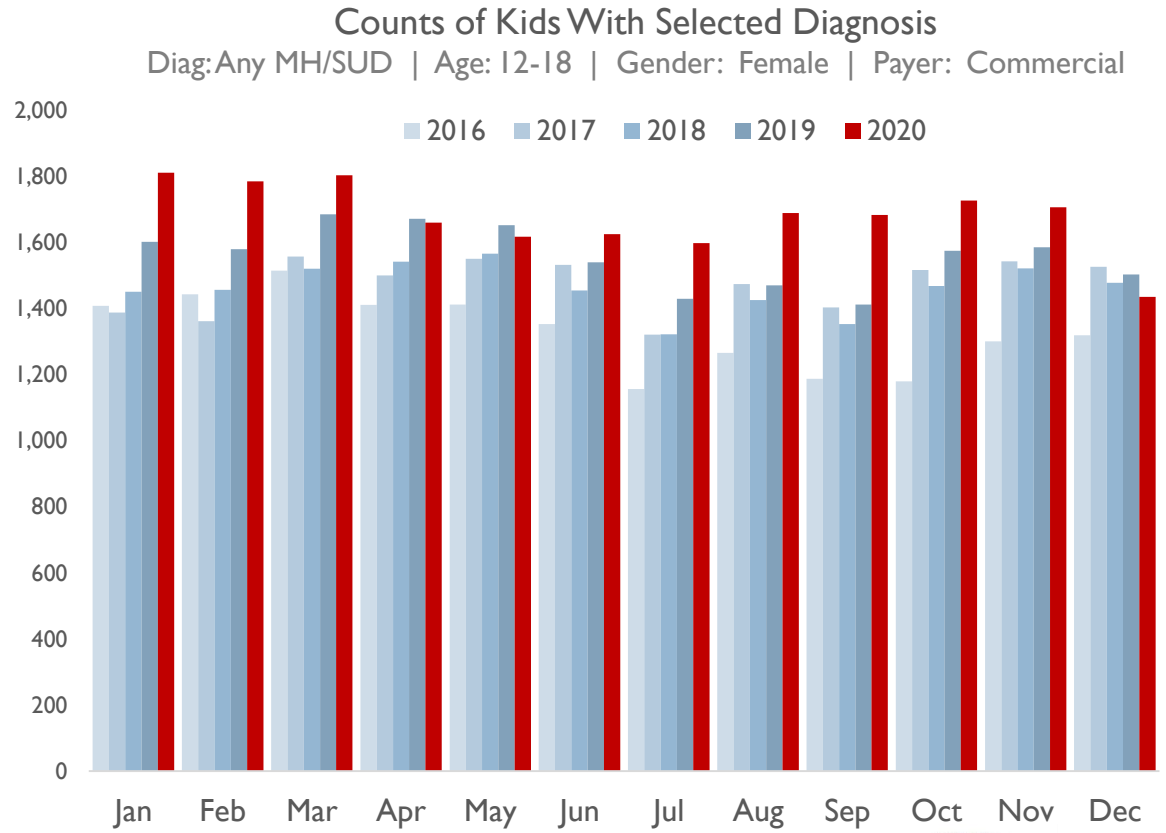
Diag: Any MH/SUD | Age: All | Gender: Any | Payer: Commercial



WITHIN THE **COMMERCIAL** POPULATION, OVERALL RATES OF MH/SUD DIAGNOSES ARE RISING QUICKLY AMONG **ADOLESCENT FEMALES**

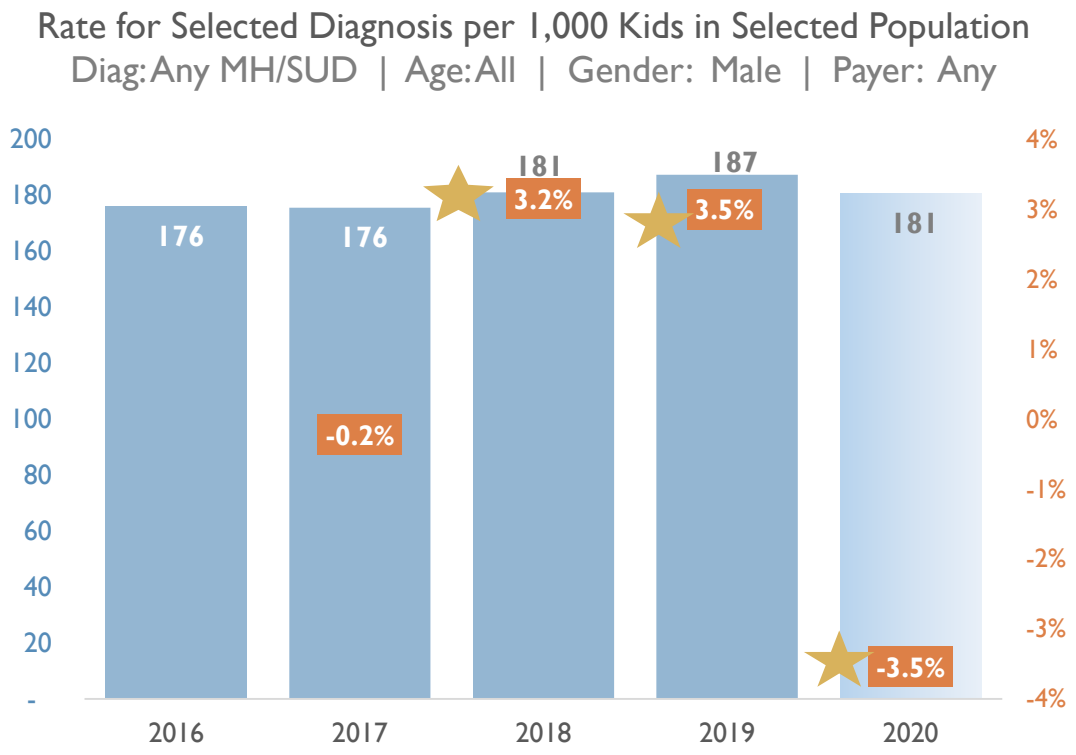
★ *Statistically significant change from prior year ($p < 0.05$)*

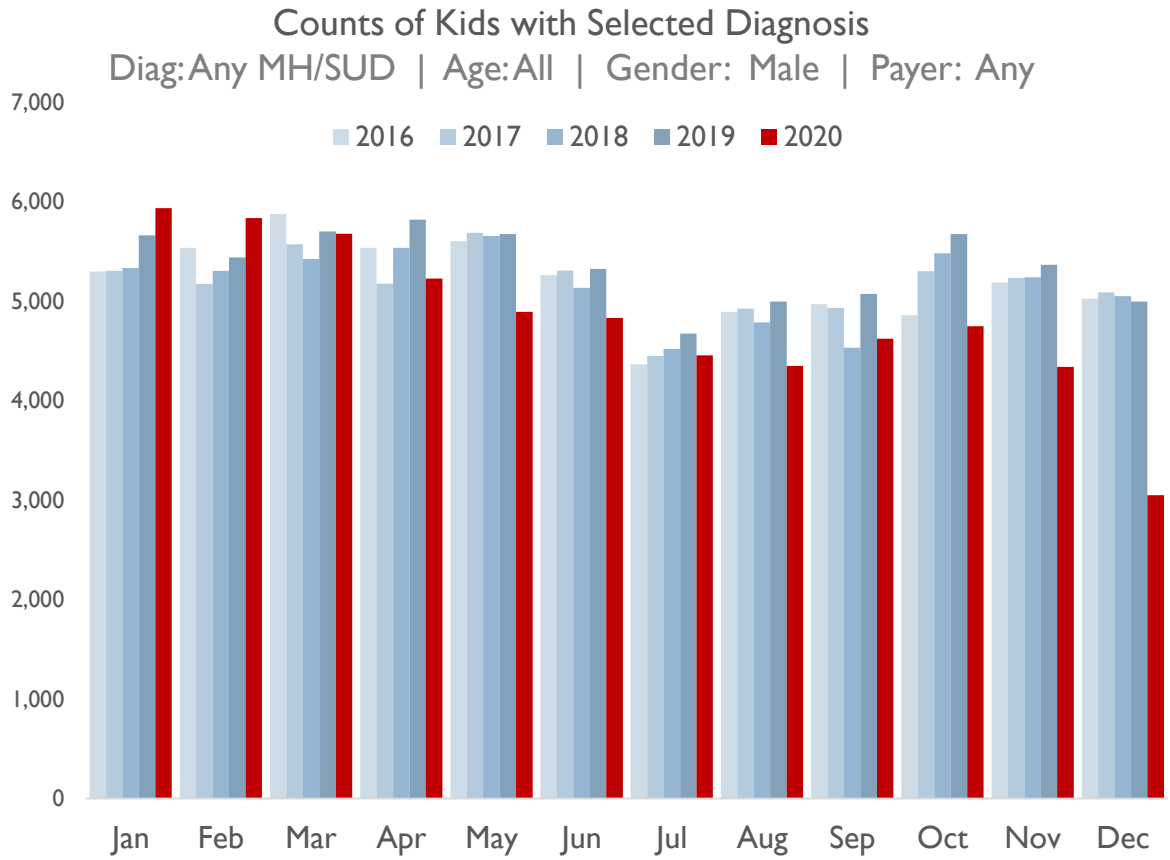




In contrast to Females, Diagnoses among **Males** fell during the pandemic

★ *Statistically significant change from prior year ($p < 0.05$)*

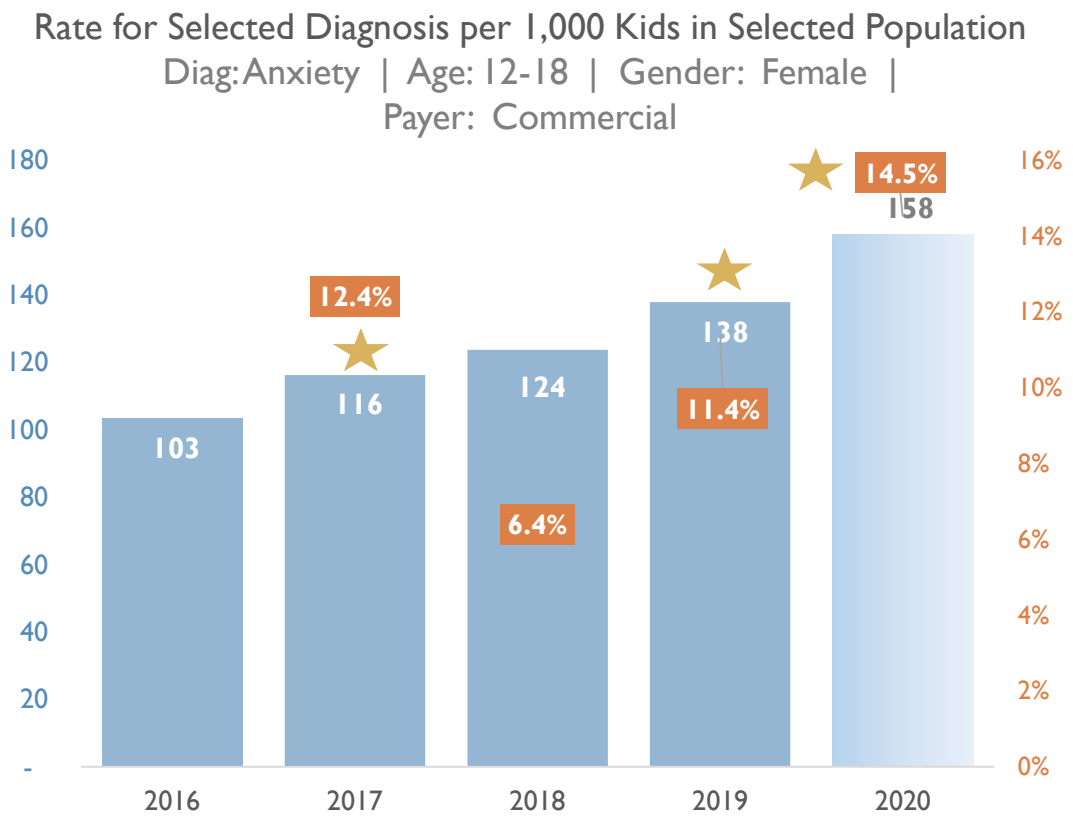


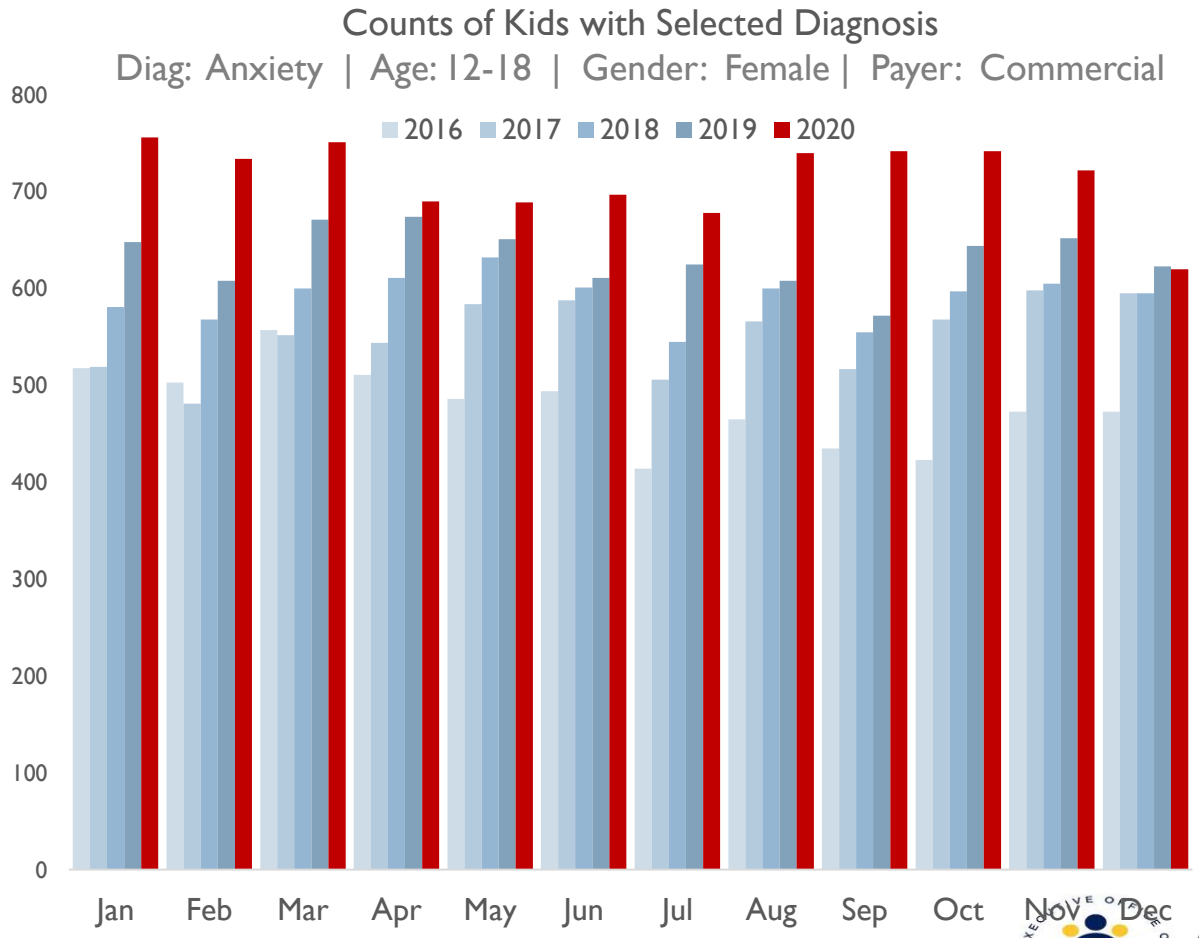


We also see spikes in common diagnoses: Depression, Anxiety

Anxiety for Adolescent females, Commercial insurance shown | Similar trends for Medicaid and for Depression

★ *Statistically significant change from prior year ($p < 0.05$)*

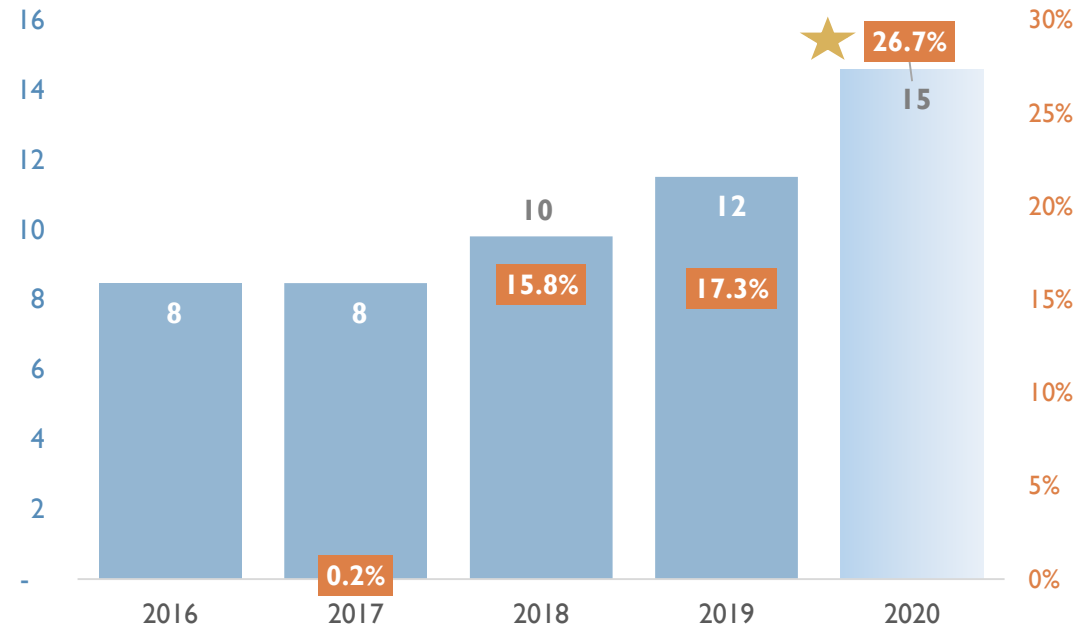




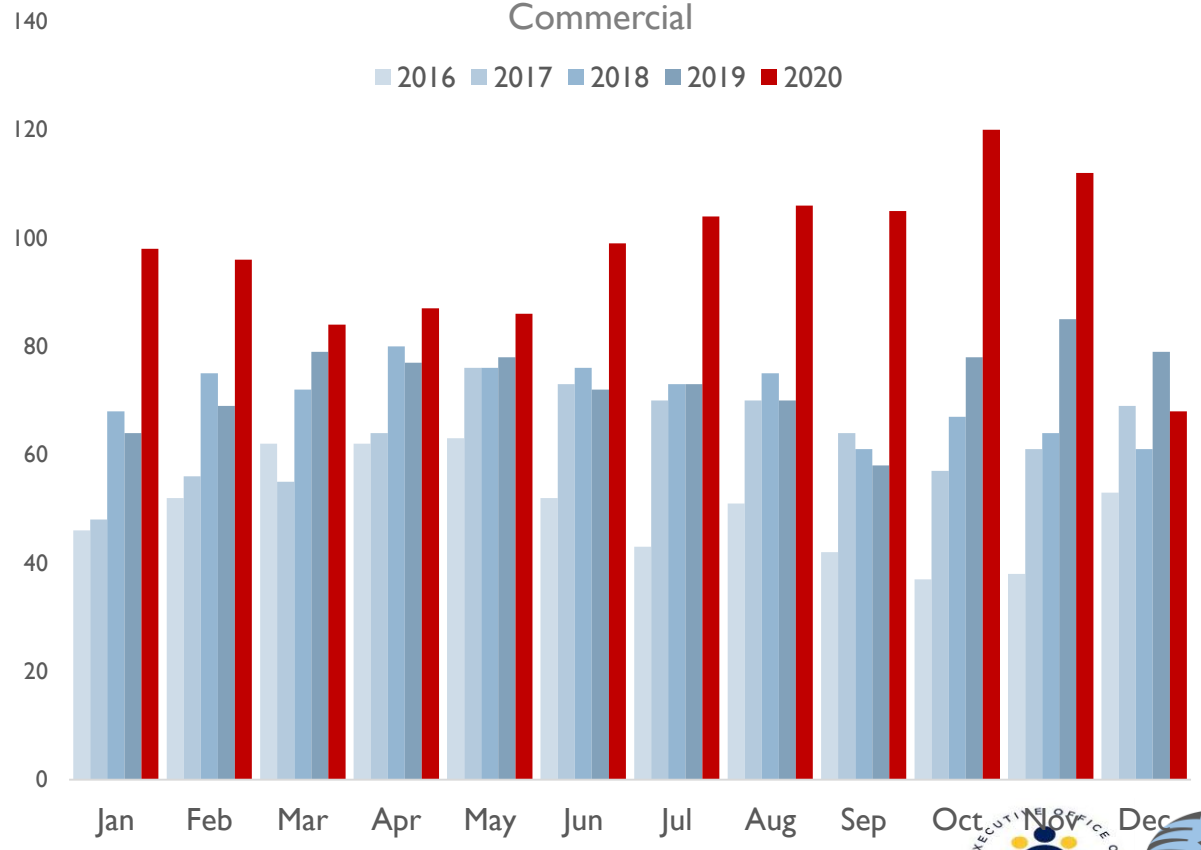
WE ALSO SEE SPIKES IN LESS COMMON DIAGNOSES: EATING DISORDERS, INSOMNIA

★ *Statistically significant change from prior year ($p < 0.05$)*

Rate for Selected Diagnosis per 1,000 Kids in Selected Population
Diag: Eating Disorder | Age: 12-18 | Gender: Female | Payer: Commercial



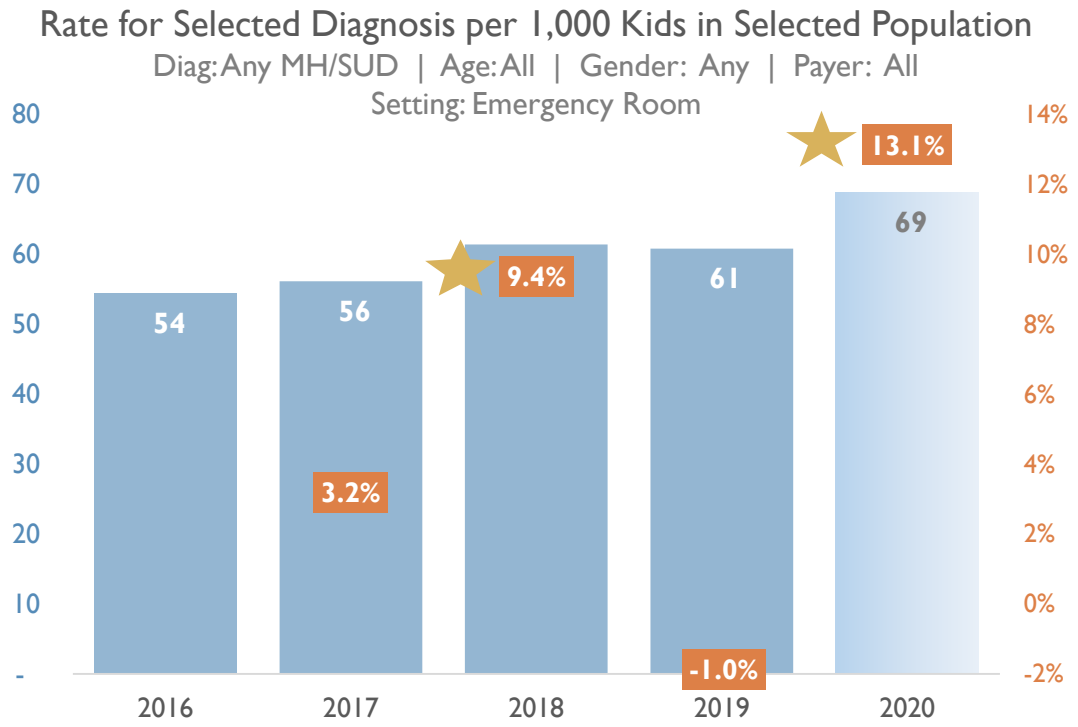
Counts of Kids with Selected Diagnosis
Diag: Eating Disorders | Age: 12-18 | Gender: Female | Payer: Commercial

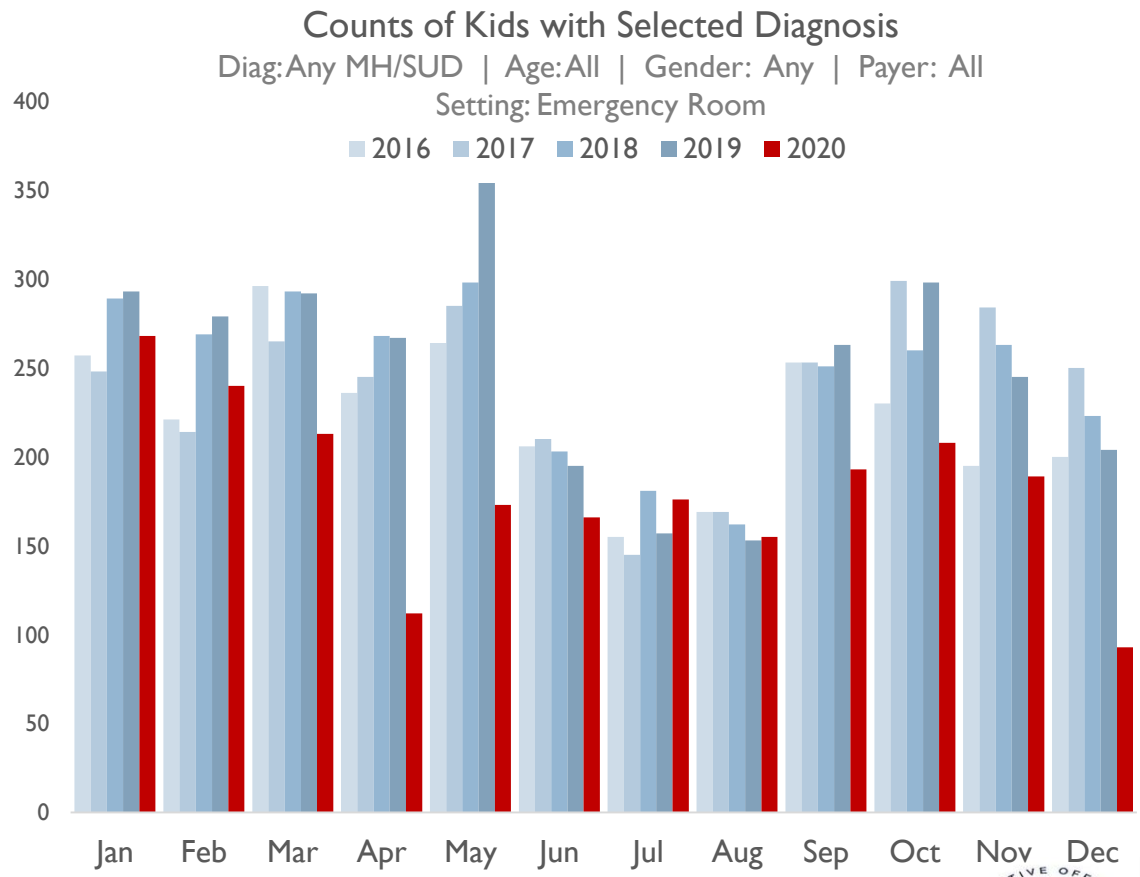


While all ED visits fell in 2020, **BH-related ED visits** as a portion of all ED visits grew by 13%

★ *Statistically significant change from prior year ($p < 0.05$)*

Note that ED events only count visits that do not result in an admission

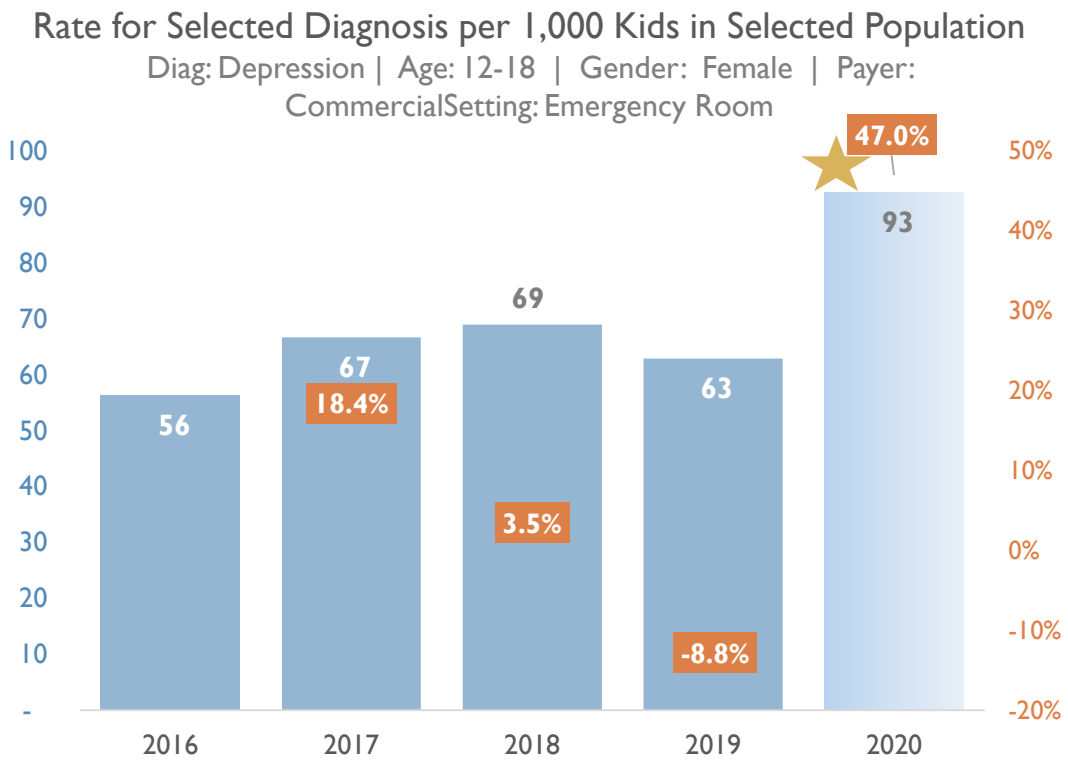


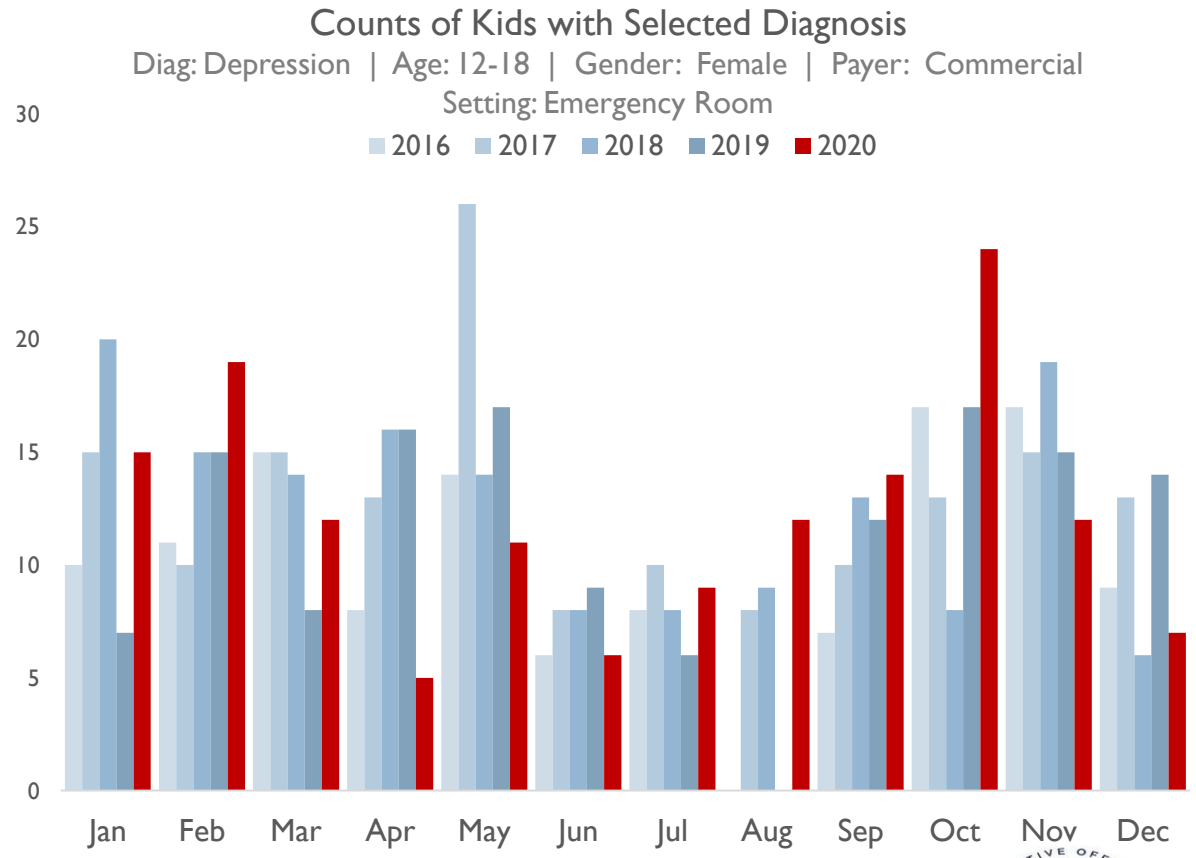


Visits for Depression in the ED for Adolescent girls (Commercial) are spiking in Q3/Q4 2020 and may continue to grow rapidly as claims come in

★ *Statistically significant change from prior year ($p < 0.05$)*

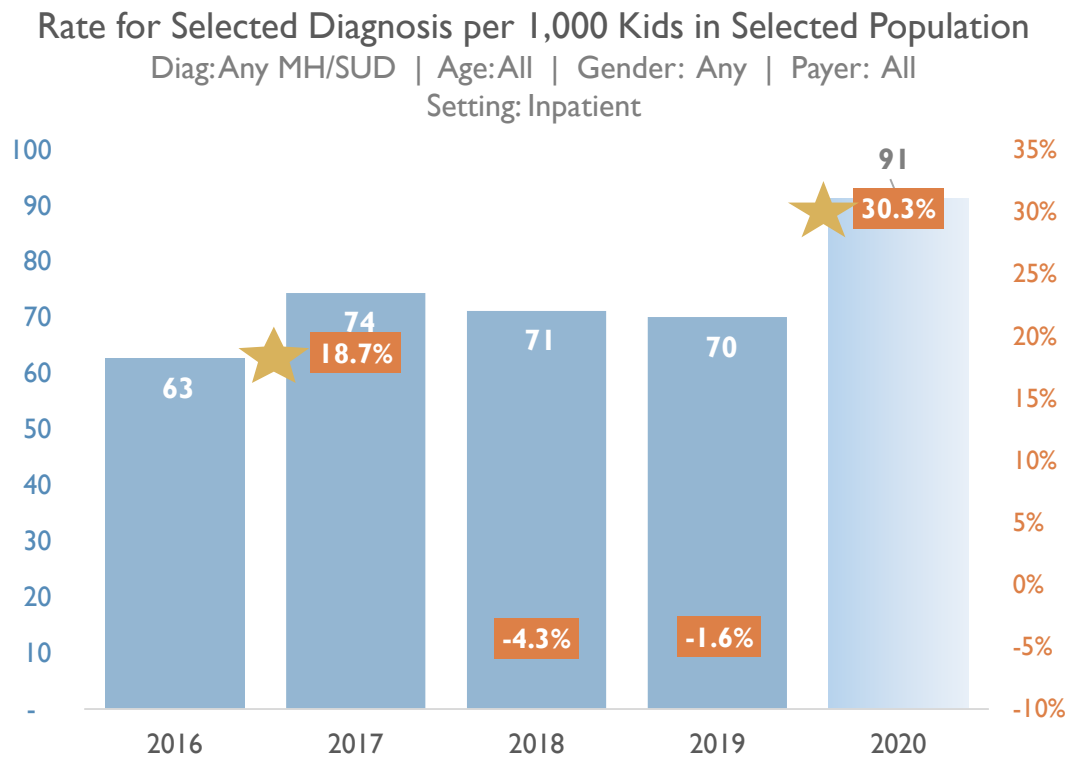
Note that ED events only count visits that do not result in an admission

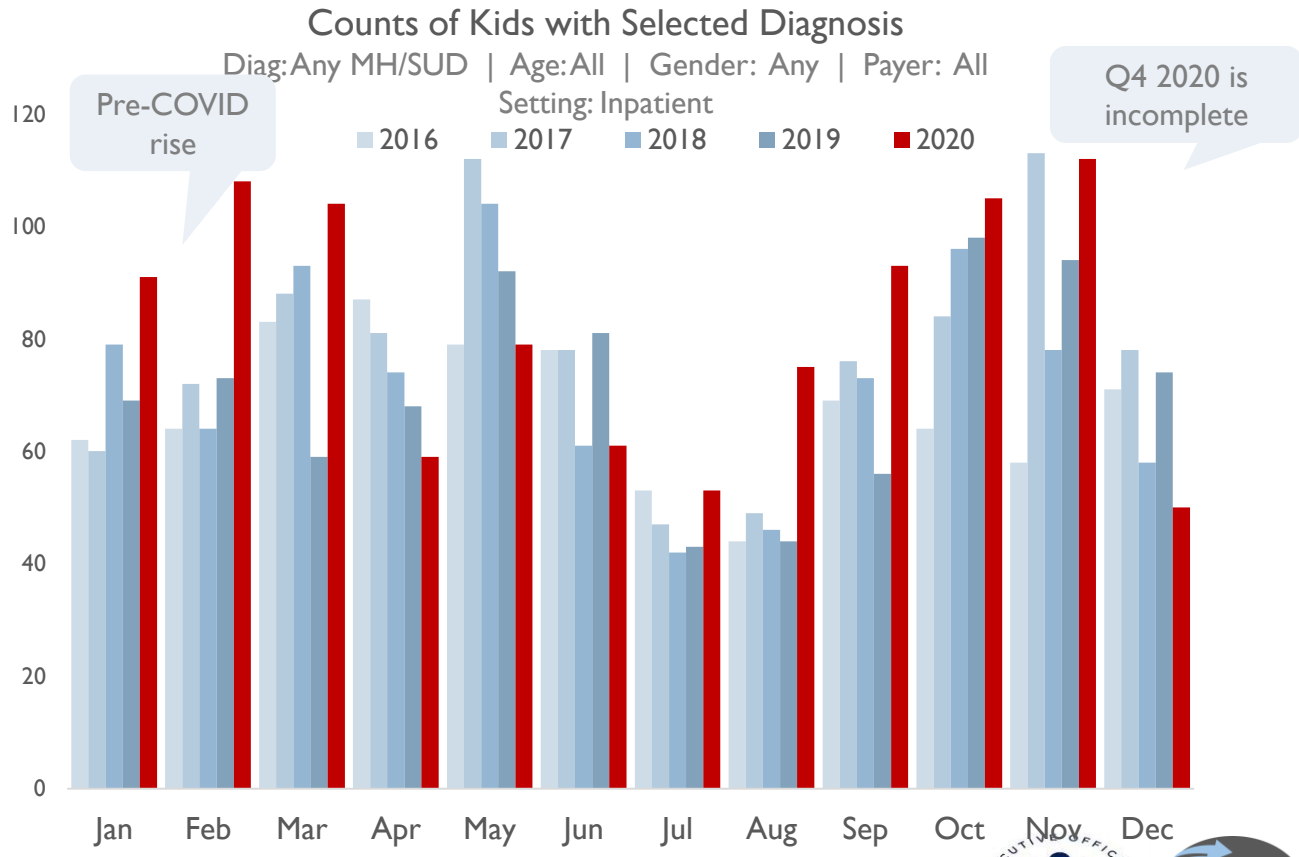




THE RATE OF **BH-RELATED INPATIENT ADMISSIONS** RELATIVE TO ALL ADMISSIONS ROSE 30% FROM 2019 - 2020

★ *Statistically significant change from prior year ($p < 0.05$)*





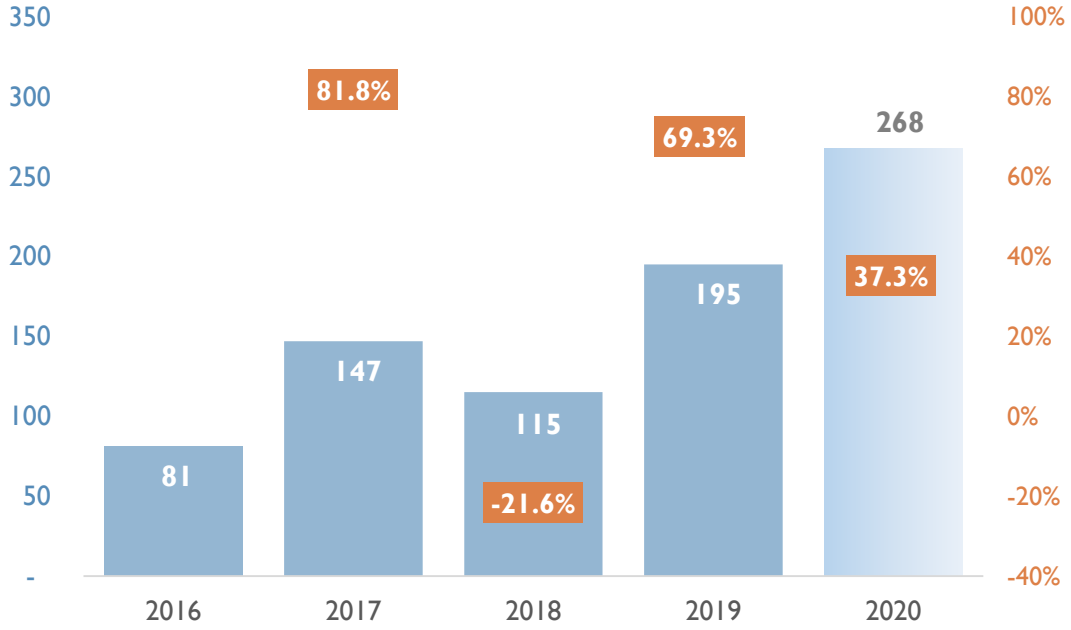
The main driver of the increase in BH-related Inpatient admissions was **Suicidal Ideation and Attempt**

Data for Adolescent Girls, Commercial and Medicaid insurance shown here

★ *Statistically significant change from prior year ($p < 0.05$)*

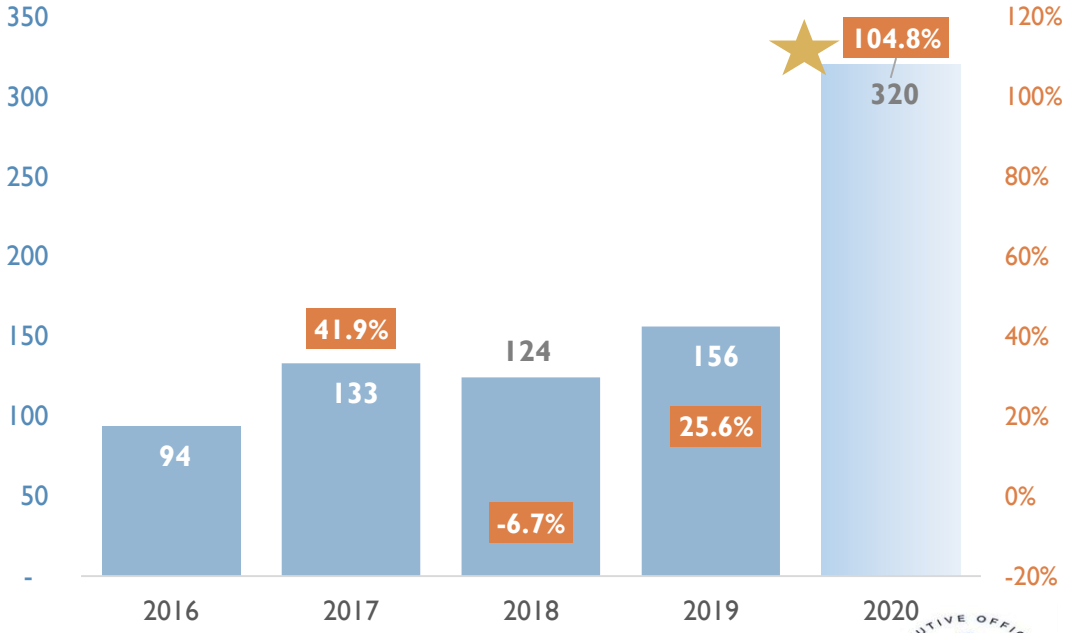
Rate for Selected Diagnosis per 1,000 Kids in Selected Population

Diag: Suicidal Ideation (not attempt) | Age: 12-18 | Gender: Female | Payer: Commercial | Setting: Inpatient



Rate for Selected Diagnosis per 1,000 Kids in Selected Population

Diag: Suicidal Ideation (not attempt) | Age: 12-18 | Gender: Female | Payer: Medicaid | Setting: Inpatient



EOHHS DATA ECOSYSTEM—INITIAL FINDINGS

Parameter	Age	Gend	Payer	Site of Care	Stat	Directic
Indivs with Anxiety	12 to 18	F	NULL	Telehealth	NO	WORSE
Indivs with Conduct Disorder	12 to 18	F	NULL	Emergency room	NO	WORSE
Indivs with Depression	12 to 18	F	NULL	Telehealth	NO	WORSE
Indivs with MHSUD	12 to 18	F	COMMERCIAL	Telehealth	NO	WORSE
Indivs with Opp Defiant Disorder	NULL	NULL	NULL	Telehealth	NO	WORSE
Indivs with PTSD	12 to 18	F	COMMERCIAL	NULL	NO	WORSE
Indivs with Suicidal Attempt	12 to 18	F	MEDICAID	NULL	NO	WORSE
Indivs with Anxiety	NULL	F	NULL	NULL	YES	WORSE
Indivs with Conduct Disorder	12 to 18	F	MEDICAID	Telehealth	YES	WORSE
Indivs with Depression	12 to 18	F	COMMERCIAL	Emergency room	YES	WORSE
Indivs with Depression	12 to 18	F	COMMERCIAL	NULL	YES	WORSE
Indivs with Eating Disorder	12 to 18	F	NULL	NULL	YES	WORSE
Indivs with Eating Disorder	12 to 18	F	NULL	Outpatient	YES	WORSE
Indivs with Eating Disorder	12 to 18	F	NULL	Telehealth	YES	WORSE
Indivs with Insomnia	NULL	NULL	NULL	NULL	YES	WORSE
Indivs with Insomnia	NULL	NULL	NULL	Telehealth	YES	WORSE
Indivs with MHSUD	NULL	F	NULL	NULL	YES	WORSE
Indivs with MHSUD	12 to 18	F	COMMERCIAL	NULL	YES	WORSE
Indivs with OCD	12 to 18	F	COMMERCIAL	Telehealth	YES	WORSE
Indivs with Overdose	12 to 18	F	COMMERCIAL	Emergency room	YES	WORSE
Indivs with Prior Hx of Self Harm	12 to 18	F	MEDICAID	Telehealth	YES	WORSE
Indivs with Self Harm Dx	12 to 18	F	NULL	Emergency room	YES	WORSE
Indivs with Suicidal Ideation	NULL	F	NULL	Emergency room	YES	WORSE

August 20th: Proposed Topics

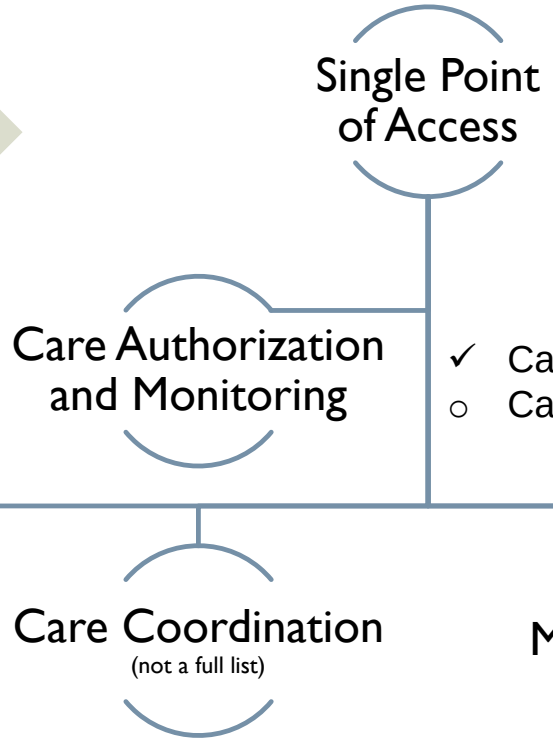
- Proposed analytic plan for the evaluation strategy
- Data sources for key metrics
- Refreshed baseline claims data
  - Medicaid through March 2021
  - September: APCD with Race and Ethnicity and more recent data

APPENDIX

KEY SLIDES FROM PREVIOUS MEETINGS

Overarching Needs/Framework Support:

Primary Prevention
Social Determinants of Health Focus
Planning with a Race Equity Lens
Workforce Transformation
Financial Sustainability – and Braided Funding, with agreement from all funders



- **Examples of Current Point(s) of Access (not a full list)**
  - ✓ Kids' Link RI
  - ✓ FCCPs
  - ✓ Medicaid MCOs
  - ✓ Commercial Insurance
  - ✓ Pediatrics
  - ✓ Community: Schools, Hospitals, CBOs

- ✓ Care authorization (decentralized)
- ○ Care monitoring and review

Key of SOC Elements

- ✓ Exists (although capacity may be below need)
- ○ Partially exists
- ✗ Doesn't exist

- ○ Broad array of home, school and community-based services, including Prevention Services
- ○ Culturally relevant intervention programs
- ○ Linguistic and culturally competent workers
- ✓ Pedi-PRN, Peds, Psych
- ○ Telehealth

- ✓ FCCPs with Wraparound
- ✓ Traditional case mgmt.
- ✓ MCO care coordination
- ✓ Health Homes
- ✓ Family Home Visiting
- ✓ Community Health Teams

- ○ Two (of 8) CMHCs received recent grants for children's mobile crisis response.
- ○ Intensive in-home services
- ✗ Respite

- ✓ Psychiatric Hospitals
- ✓ Acute Residential Treatment Services
- ✓ PRTF
- ✓ Group homes
- ✓ Specialized foster care
- ✗ Adolescent Substance

Data + Eval Team: Planning + Organizing

Key resources:

- *Website for Children's Behavioral Healthcare System*
- *Notes from 6/14*
- *Jamboard on Racial Justice in our Eval*
- *RISPA Suicide Prevention Protocol*

Upcoming meetings

- August 16th
- September 20th
- October 18th
- November 15th
- December 20th

Major Data + Eval Team Functions + Decisions

- Identify community advisors including school community
- Inform ourselves on roots of racial disparities and ensure racial justice focused approach
- Decide + Define outcome and process metrics
- Define evaluation strategy / analytic plan
- Review and interpret quarterly updates

Children's Behavioral Health System of Care: Goals and Activities

"Support our work to strengthen RI's system of care for children experiencing behavioral health (BH) crises"

Population: Children up to age 21 in or at risk of behavioral health crisis including serious emotional disturbance (SED), first episode psychosis (FEP) or substance use disorder (SUD).

Geography: Statewide, with initial emphasis on Providence and Woonsocket

Major Activities:

1. Improve state governance to streamline operations and ensure a stronger system-wide response for children's BH care.
2. Single point of access for families to get connected to appropriate crisis care
3. Mobile Response and Stabilization Services (MRSS): 24/7 emergency services through a statewide mobile response + 30-day stabilization service.
4. Community Referral Platform (CRP): ensure that families have the full range of SDOH services through participation in the implementation of a statewide technology

Table 1: Unduplicated Individuals Served by MRSS

	Year 1	Year 2	Year 3	Year 4	Total
Individuals Enrolled in Mobile Response Stabilization Services (MRSS)	175	250	300	350	3333 33

If the RISCOC is successful, we will see:

1. Governance: New cross-agency workflows and points of accountability; Pub/pvt SteerCo
2. SPoA: fewer calls for emergency dispatch; Growing, appropriate, and high satisfaction use of the SPoA
3. MRSS: Fewer hospitalizations and res. treatment stays; Lower waiting lists
4. CRP: High and growing use; growing # of providers

KEY POINTS FROM 5/10

- What protective factors, strengths, or resilience measures exist to help keep kids in an appropriate level of care?
- Equity in behavioral health needs to be a key focus – especially for those whose primary language is not English
- Continuity of care – what happens after the ED and among milestones on the patient journey
- Interest in understanding what services – especially prevention and community-based care – exist in the state.

KEY POINTS FROM 5/10

- Schools are a key stakeholder here – faculty, staff, counselors, clinicians, and parents of students – and haven't necessarily been well-connected to the rest of the system
- Low provider rates may limit providers' ability to fully coordinate care as needed
- How do we make sure we adhere to data use and consent considerations?

SCOPE OF THIS TEAM

Outcome Goals: Support ongoing process evaluation

- Organize data collection from vendors supporting the Single Point of Access, Mobile Response + Stabilization Services, and the Community Referral Platform
  - Ensure data sources contain necessary information and can integrate – where relevant – to the Ecosystem or will otherwise be sent regularly to our team
- Report baseline and ongoing data updates for highly restrictive care and child BH crisis trends
  - Define measurable process and outcome goals
  - Define data sources, calculations, and metrics
  - Define populations and population splits
  - Define evaluation approach

DATA ECOSYSTEM: WHAT DOES "RACE-EXPLICIT" MEAN?

All study and focus areas will have race-explicit* orientations

We will center all our efforts in race equity: how institutional, societal, and interpersonal racism has worsened the health, well-being, and economic opportunity outcomes for Black, Indigenous, and People of Color (BIPoC).

Community Advisor Group

A race-explicit framework and a race equity lens includes:

- Study planning explicitly seeks to understand the role racism plays in the outcome(s)
  - Example (Overdose): Ensure that our data respond to how criminalization, systemic racism and institutional bias have dramatically worsened outcomes and closed off pathways to healing and recovery for many people of color.
- Study planning includes a representative group of BIPoC stakeholders who can **co-design solutions** and guide the analytic questions, data use, interpretation, and impact from start to finish.
  - Where possible, the Ecosystem team *goes to* existing forums, as well as invites folks into standalone forums
- Study intent explicitly seeks to support, not punish or further harm, BIPoC populations or populations who have historically been subject to racism
- All analyses show results by race, ethnicity and other key demographics (age, gender, SOGI, location) where possible – and identify means for completing data where not possible
- Acknowledge the role the state may have in perpetuating these harms and seek healing, community-led, anti-racists paths forward as part of the study's findings and recommendations.

Race explicit — speaking about race or racism without vagueness, implication, or ambiguity. One example of this is to talk about how racial profiling can escalate into police brutality.

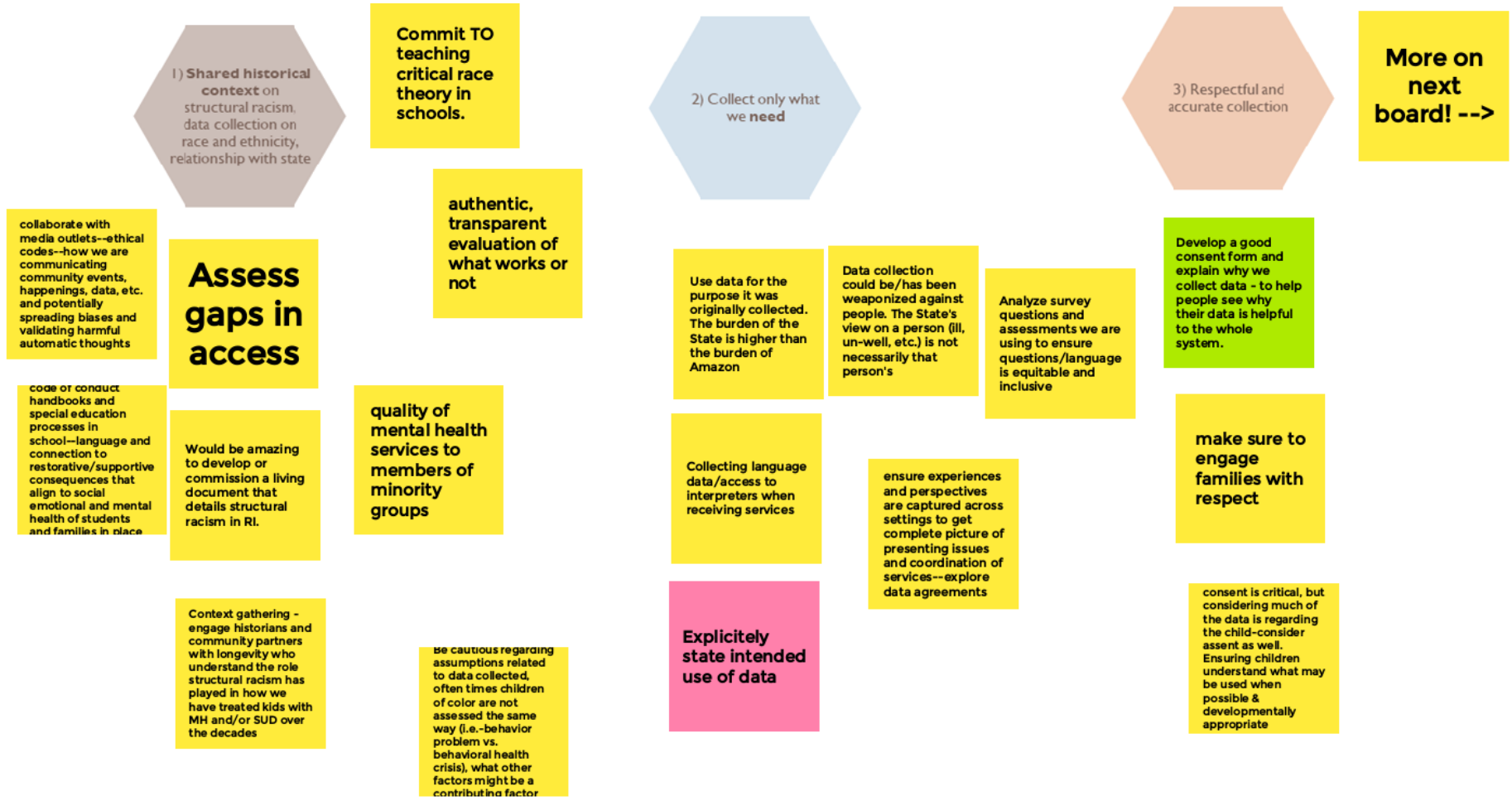
Race neutral — an attempt to create policies, remedies, or options without giving special advantage to individuals based on race and racial affiliation.

Race silent — a conscious or unconscious suppression of racial discussion in public discourse in an attempt to create a "color-blind" society in which race is neither recognized nor discussed.

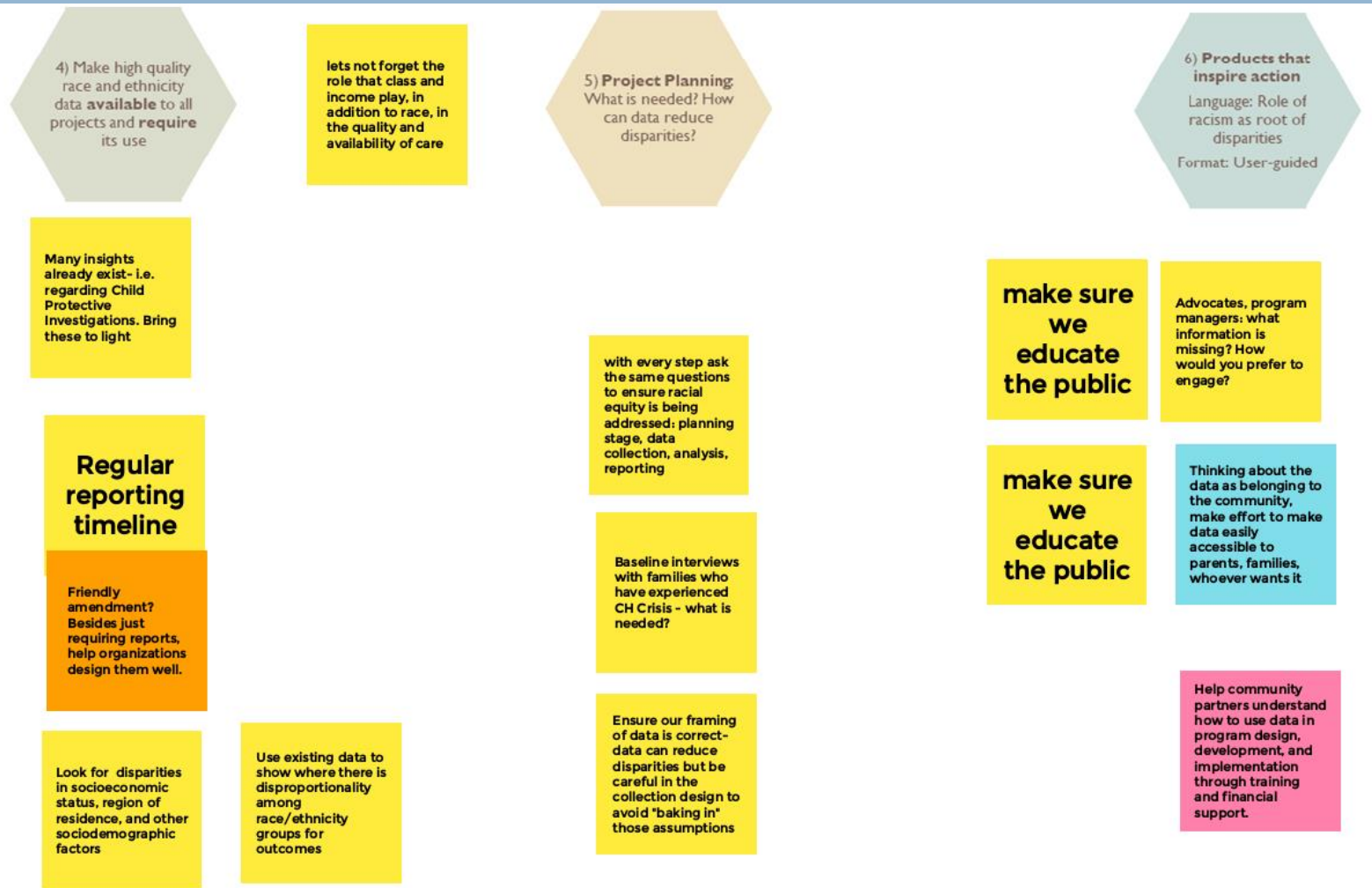
What does 'Centering Racial Justice in Integrated Data' mean to us?

Racism is a public health crisis. How can our data and language promote equity in actions, decisions, and understanding?

Jamboard: Ensuring Racial Justice in our Eval



Jamboard: Ensuring Racial Justice in our Eval



EOHHS Data Ecosystem—Methods

- Data was pulled from RI APCD data, across all payers, for the five consecutive calendar years 2016, 2017, 2018, 2019, 2020
- Inclusion: 1) Aged 18 years or less at the date of service, 2) RI resident, 3) claim processed by primary payer. Denied claims were not included
- Caveats and notes:
  - **Fall 2020 data is incomplete, especially for Medicaid.** New data refresh by end of July is expected to provide up-to-date data.
  - Telehealth was sparsely utilized prior to 2020. Caution is advised in interpreting rate and raw count changes.
  - The phrase "NULL" in a given demographic column is used to indicate all values. So, under the "Age" column, "NULL", refers to all age bands.