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
- 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

<table>
<thead>
<tr>
<th>Lack of Clarity for Parents</th>
<th>Lack of Alignment within the System</th>
<th>Need for a More Organized System</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>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.</td>
<td>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.</td>
</tr>
</tbody>
</table>
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

Mobile Crisis

Significant Investment in Workforce Transformation

Wraparound coordination

HCBS, incl. Intensive

Strong Community Outreach & Family Engagement

Residential

Sustainable & Braided Funding

Universal Screening and Prevention Activities, with a Focus on the Social Determinants of Health

SPoA for the entire system

Data collection and evaluation

Care authorization
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
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

Key resources:

- [Website for Children’s Behavioral Healthcare System](#)
- [Notes from 6/14](#)
- [Jamboard on Racial Justice in our Eval](#)
- [RISPA Suicide Prevention Protocol](#)
### How will we measure success?  
**Outcomes Metrics**

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

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

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

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

**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**

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

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

All metrics will be tracked by race, ethnicity, gender, age group.
https://miro.com/app/board/o9J_l57qtCU=/

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

  - 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.
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*

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

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

Q4 2020 is incomplete

Pre-COVID increase
Held steady through pandemic

Statistically significant change from prior year (p < 0.05)
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)

**Rate for Selected Diagnosis per 1,000 Kids in Selected Population**
Diag: Any MH/SUD | Age: 12-18 | Gender: Female | Payer: Commercial

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>239</td>
<td></td>
</tr>
<tr>
<td>2017</td>
<td>255</td>
<td>6.5%</td>
</tr>
<tr>
<td>2018</td>
<td>267</td>
<td>4.7%</td>
</tr>
<tr>
<td>2019</td>
<td>289</td>
<td>8.4%</td>
</tr>
<tr>
<td>2020</td>
<td>317</td>
<td>9.4%</td>
</tr>
</tbody>
</table>

**Counts of Kids With Selected Diagnosis**
Diag: Any MH/SUD | Age: 12-18 | Gender: Female | Payer: Commercial

- 2016
- 2017
- 2018
- 2019
- 2020
IN CONTRAST TO FEMALES, DIAGNOSES AMONG MALES FELL DURING THE PANDEMIC

Rate for Selected Diagnosis per 1,000 Kids in Selected Population
Diag: Any MH/SUD | Age: All | Gender: Male | Payer: Any

Counts of Kids with Selected Diagnosis
Diag: Any MH/SUD | Age: All | Gender: Male | Payer: Any

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)

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

Diag: Anxiety | Age: 12-18 | Gender: Female | Payer: Commercial

Counts of Kids with Selected Diagnosis

Diag: Anxiety | Age: 12-18 | Gender: Female | Payer: Commercial

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%.

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

Statistically significant change from prior year (p < 0.05)
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)

Rate for Selected Diagnosis per 1,000 Kids in Selected Population
Diag: Depression | Age: 12-18 | Gender: Female | Payer: Commercial
Setting: Emergency Room

Count of Kids with Selected Diagnosis
Diag: Depression | Age: 12-18 | Gender: Female | Payer: Commercial
Setting: Emergency Room
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

![Graph showing the rate of BH-related inpatient admissions per 1,000 kids in selected population from 2016 to 2020.](Image)

Statistically significant change from prior year (p < 0.05)

Counts of Kids with Selected Diagnosis

<table>
<thead>
<tr>
<th>Setting: Inpatient</th>
<th>Age: All</th>
<th>Gender: Any</th>
<th>Payer: All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4 2020 is incomplete</td>
<td>Pre-COVID rise</td>
<td>2016</td>
<td>2017</td>
</tr>
</tbody>
</table>

Q4 2020 is incomplete
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)
## EOHHS DATA ECOSYSTEM—INITIAL FINDINGS

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Age</th>
<th>Gender</th>
<th>Payer</th>
<th>Site of Care</th>
<th>Stat Signif.</th>
<th>Direction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indivs with Anxiety</td>
<td>12 to 18</td>
<td>F</td>
<td>NULL</td>
<td>Telehealth</td>
<td>NO</td>
<td>WORSE</td>
</tr>
<tr>
<td>Indivs with Conduct Disorder</td>
<td>12 to 18</td>
<td>F</td>
<td>NULL</td>
<td>Emergency room</td>
<td>NO</td>
<td>WORSE</td>
</tr>
<tr>
<td>Indivs with Depression</td>
<td>12 to 18</td>
<td>F</td>
<td>NULL</td>
<td>Telehealth</td>
<td>NO</td>
<td>WORSE</td>
</tr>
<tr>
<td>Indivs with MHSUD</td>
<td>12 to 18</td>
<td>F</td>
<td>COMMERCIAL</td>
<td>Telehealth</td>
<td>NO</td>
<td>WORSE</td>
</tr>
<tr>
<td>Indivs with Opp Defiant Disorder</td>
<td>NULL</td>
<td>NULL</td>
<td>NULL</td>
<td>Telehealth</td>
<td>NO</td>
<td>WORSE</td>
</tr>
<tr>
<td>Indivs with PTSD</td>
<td>12 to 18</td>
<td>F</td>
<td>COMMERCIAL</td>
<td>NULL</td>
<td>NO</td>
<td>WORSE</td>
</tr>
<tr>
<td>Indivs with Suicidal Attempt</td>
<td>12 to 18</td>
<td>F</td>
<td>MEDICAID</td>
<td>NULL</td>
<td>NO</td>
<td>WORSE</td>
</tr>
<tr>
<td>Indivs with Anxiety</td>
<td>NULL</td>
<td>F</td>
<td>NULL</td>
<td>NULL</td>
<td>YES</td>
<td>WORSE</td>
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<tr>
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<td>Telehealth</td>
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<td>Outpatient</td>
<td>YES</td>
<td>WORSE</td>
</tr>
<tr>
<td>Indivs with Insomnia</td>
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<td>NULL</td>
<td>NULL</td>
<td>NULL</td>
<td>YES</td>
<td>WORSE</td>
</tr>
<tr>
<td>Indivs with MHSUD</td>
<td>NULL</td>
<td>NULL</td>
<td>NULL</td>
<td>Telehealth</td>
<td>YES</td>
<td>WORSE</td>
</tr>
<tr>
<td>Indivs with MHSUD</td>
<td>12 to 18</td>
<td>F</td>
<td>COMMERCIAL</td>
<td>NULL</td>
<td>YES</td>
<td>WORSE</td>
</tr>
<tr>
<td>Indivs with OCD</td>
<td>12 to 18</td>
<td>F</td>
<td>COMMERCIAL</td>
<td>Telehealth</td>
<td>YES</td>
<td>WORSE</td>
</tr>
<tr>
<td>Indivs with Overdose</td>
<td>12 to 18</td>
<td>F</td>
<td>COMMERCIAL</td>
<td>Emergency room</td>
<td>YES</td>
<td>WORSE</td>
</tr>
<tr>
<td>Indivs with Prior Hx of Self Harm</td>
<td>12 to 18</td>
<td>F</td>
<td>MEDICAID</td>
<td>Telehealth</td>
<td>YES</td>
<td>WORSE</td>
</tr>
<tr>
<td>Indivs with Self Harm Dx</td>
<td>12 to 18</td>
<td>F</td>
<td>NULL</td>
<td>Emergency room</td>
<td>YES</td>
<td>WORSE</td>
</tr>
<tr>
<td>Indivs with Suicidal Ideation</td>
<td>NULL</td>
<td>F</td>
<td>NULL</td>
<td>Emergency room</td>
<td>YES</td>
<td>WORSE</td>
</tr>
</tbody>
</table>
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

DRAFT CORE ELEMENTS OF PROPOSED SYSTEM OF CARE FOR CHILDREN

Single Point of Access

- Care Authorization and Monitoring
  - Care authorization (decentralized)
  - Care monitoring and review

Community
- 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

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

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

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

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

Key of SOC Elements
- Exists (although capacity may be below need)
- Partially exists
- Doesn't exist
**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

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

Table 1: Unduplicated Individuals Served by MRSS

<table>
<thead>
<tr>
<th>Individuals Enrolled in Mobile Response Stabilization Services (MRSS)</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>175</td>
<td>250</td>
<td>300</td>
<td>350</td>
<td>3333</td>
<td>33</td>
</tr>
</tbody>
</table>
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).

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?

Co-Design with Community

1) Shared historical context on structural racism, data collection on race and ethnicity, relationship with state

2) Collect only what we need

3) Respectful and accurate collection

4) Make high quality race and ethnicity data available to all projects and require its use

5) Project Planning: What is needed? How can data reduce disparities?

6) Products that inspire action
   Language: Role of racism as root of disparities
   Format: User-guided
JAMBOARD: ENSURING RACIAL JUSTICE IN OUR EVAL

1) Shared historical context on structural racism, data collection on race and ethnicity, relationship with state

2) Collect only what we need

3) Respectful and accurate collection

Assess gaps in access

- Collaborate with media outlets to cover issues, how we are communicating community events, happenings, data, etc.
- Look for patterns and spreading biases and validating harmful automatic thoughts
- Code or consult handbooks and special education processes in school—language and connection to restorative/compassionate consequences that offer social emotional and mental health of students and families in state

Conduct gathering—engage historians and community partners with frequency to understand the role structural racism has played in how we have treated/led with W/D and/or W/O over the decades

Commit to teaching critical race theory in schools

- Authentic, transparent evaluation of what works or not
- Use data for the purpose it was originally collected. The burden of the State is higher than the burden of Amazon
- Data collection could be has been weaponized against people. The State’s view on a person [ill, un-well, etc.] is not necessarily that person’s
- Collecting language data/access to interpreters when receiving services
- Ensure experiences and perspectives are captured across settings to get complete picture of presenting issues and coordination of services—explore data agreements

Explain state intended use of data

- Consent is critical, but considering much of the data is regarding the child, consider asset as well
- Ensuring children’s privacy and potential in the classroom that may be used when possible & developmentally appropriate

More on next board! -->
JAMBOARD: ENSURING RACIAL JUSTICE IN OUR EVAL

4) Make high quality race and ethnicity data available to all projects and require its use

Many insights already exist - i.e., regarding Child Protective Investigations. Bring these to light.

5) Project Planning: What is needed? How can data reduce disparities?

with every step ask the same question to ensure racial equity is being addressed. Planning stages, data collection, analysis, reporting.

Baseline interviews with families who have experienced CH Crisis - what is needed?

Use existing data to show where there is disproportionality among race/ethnicity groups for outcomes.

Ensure our framing of data is correct - data can reduce disparities but be careful in the collection design to avoid "building in" those assumptions.

Regular reporting timeline

Friendly amendment? Revisit just requiring reports, help organisations design them well.

Look for disparities in socioeconomic status, region of residence, and other sociodemographic factors.

make sure we educate the public

Advocates, program managers: what information is missing? How would you prefer to engage?

Thinking about the data as belonging to the community, make effort to make data easily accessible to parents, families, whoever wants it.

Help community partners understand how to use data in program design, development, and implementation through training and financial support.

make sure we educate the public
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.