Meeting date, time, location: 8.4.21, 3pm, videoconferencing

Leader: Susan Lindberg and Kayla David

Participants: Susan Lindberg (DCYF), Maayan Rosenfield (EOHHS), Sarah Kelly-Palmer (Vice President of Healing Division, Family Service of Rhode Island), Joe Robitaille (VP Childrens Services at Trudeau Center), Shannon Ciccone (Perspectives Corp. Clinical Director), Marcia Tryon (Manager of Children Services at Newport Mental Health), Kayla David (LMFT Healing Division Director at Family Service of Rhode Island), Jenna Chaplin (Assistant VP of Treatment Programs- Tides Family Services), Ellie Rosen (EOHHS), Rena Sheehan (BCBSRI), Laura Scussel (Thrive Behavioral Health Program Manager of Youth and Family Services), Maria Terrero-Kamara (Clinical Social Worker, Community Services Behavioral Health DCYF), Sarah Sparhawk (Chief Implementation Aide - DCYF CSBH), Emily Matthews (Clinical Supervisor Trauma Response Team, FSRI), Naiommy Baret, Cindy Gordon, H Sachs, Emily Matthews

Recap of previous workgroup	Kayla David and Susan Lindberg	• Been thinking about Faulkner Consulting report, thinking about the mobile crisis agenda item • Also ARPA 85% FMAP through April 2022 for first 3 years of mobile crisis • Thinking about what other states/groups doing for mobile crisis and response teams • Learned that what currently exists for mobile crisis is very limited • Faulkner is working on developing Mobile Crisis Implementation plan – need to be working on recommendations for them • Our crisis components are: SPoA, MRSS (longterm stabilization and make sure access services), system coordination and community collaboration (work with schools, providers, welfare, community orgs, hospital, juvenile justice, etc), workforce strategies, financing a crisis continuum of care
Mobile response and Stabilization Services Recommendations		• Thinking about best practice elements of MRSS: Crisis defined by caller, services constantly available, rapid response, serve children and families in natural environment at home or in school, immediate de-escalation/stabilization and family guided safety plan, gatekeepers for higher levels of services, specialized child and adolescent trained staff, standardized screening and assessment, immediate access to psych consultaion support and medication review, provide stabilization services including in home and respite care, stabilization might continue over a few days to a few weeks based on needs of fam, coordinate care with existing providers, build on natural support structures (limit inpatient and hospital reliance), connect families with follow-up services and supports, need specialized teams for services and train staff to be aware for unique issues presenting for families, must be accessible to all children – what would that look like how do we do that?

		- Susan: feedback? - Joe Robitaille: What would it mean for MR and longer term services to work together for a smoother handoff? How to bill for both without double billing problem - Susan: great point - Joe: problem of revolving doors of ppl going down levels of care then back up, could be solved with better handoffs - Rena Sheehan: If MRSS is gatekeeper, can they avoid ED visit to go inpatient? - Susan: that's the goal - Laura Scussel: if we saw a kid that couldn't make a safety plan, they'd likely still go to ED but many families aren't at that point - Cindy Gordon: Sometimes mobile crisis team will do evaluation but will need to go to ED for medical clearance, but the goal always is to avoid ER. But some families have felt more comfortable going to ER - still lack of understanding on what mobile crisis and psychiatric crisis are in MA even when been long established - Kayla David: when don't have clinical team that's been working w fam, miss a lot of info – case worker can't sit on assessment if don't have both there, need the context info - Laura Scussel: the key thing about how long these services last is finding the what comes next and it's all based on that - Sarah Kelly Palmer: I agree with everything presented but at the forefront of our minds is have to remember that the crisis team can't just be managing all the cases because don't have place to hand off to - Jenna Chaplin: at TIDES we've been doing this and it's the response time and handoff time that we're trying to get down – can't hold cases in other programs, need to get as many clients in and out for crisis intervention. Also having them trained in MI. - Laura Scussel: Just having ability to have the quick access has been imperative – availability for this kind of staffing does cost a lot, involves lots of staff and also need for availability – need psychiatrists, case managers - Susan: yeah for firehouse model we need staff to do it and we need to pay staff for availability and timing. - Jenna Chaplin: biggest concern from staff when we were interviewing for mobile crisis is what will the timing and schedules like - Sarah Palmer: people are being pushed to the edge because they also have full time job – need this to not be an add-on, must be a full time job. - Susan: Yes, need at least 50 full time staff if not more.

SPoA		• Susan: Want to talk about SPoA for crisis continuum rather than whole system. We need to make it available to everyone. What are the core parts of SPoA for crisis system.
		• Let's discuss and think about some of the challenges:
		  o Adding more families and demand to already overburdened system – if find exactly what they need and then huge wait time it's gonna be a major issue
		  o Multiple payers, each with differing eligibility criteria, reimbursement, etc – limited based on payer and system involvement which services can get
		• Sarah: workforce – love the idea of 50 clinicians to do this – how do you find 50 to do it. Need campaign to bring BH staff to RI
		• Susan: yeah we're really at crisis point needing more staff
		• Rena: make sure people know what's available – we have services we've tried to advertise but no one needs
		• Kayla David: How to fund firehouse model when only get paid for seeing patient – need to get paid even if no one using crisis at the moment. Also funding openings for outpatient/lower caseloads at different points of care
		• Shannon Ciccone: need better collaboration with doctors who are diagnosing bc that's where majority of referrals come from. Need to be told what to do, where services available – need better relationships with Hasbro, CNDC, packet of info to help families navigate all the resources out there, really unable to tap into other resources. AVA is medical necessity so work with community insurers, what we can't bill we work into medical models. Tapping into hierarchy where point person is licensed but bachelor's level employees that are really capable. Can't bill commercially but can bill medicaid. Some commercial families don't even know they need that secondary insurer.
		• Joe: All families get denied for secondary service initially and then send folks to RIPEin to help them navigate – have to redo application lots of times, really gets in the way
		• Shannon Ciccone: 90 day waittime to connect, Katy Beckett form is big chore, takes really long time to apply for the secondary insurance coverage. Really tough getting this coverage in non-immediate scenario.
		• Sarah: UniteUS – quick access to data and data-sharing, need to be able to access emergency assessment
		• Susan: medicaid is looking at UniteUS, thinking about SDOH from their end but also about behavioral health
		• Joe: system overall sounds like great idea – which comes first --> gotta establish workforce before even establish this or this is just going to fall apart. Need to focus on rates and

		wages first. Last thing we want is have families refer to a waitlist. • Kayla: what are key considerations as work to develop pathway? Joe made the point we need a workforce first • Sarah: getting funders on board, being thoughtful abt that from beginning • Rena: decide what is the finance model? FFS? Bundled? Is one preferable? • Susan: hopefully SAMHSA grant and other sources will fund SPoA, but yes really important for services. We have KidsLink which has been around for a while and is in place now for point of access for BH crisis • Kayla: like the idea of the way CEDAR was run, Ocean Link/state(?) and take consideration about how they operated collaboratively • Susan: glad you brought up CEDAR because work with kids with developmental needs and do do that work. We also have family care community partnership. There's all different kinds of groups that come in with different needs – having clearly delineated programs and assessment for diff needs • Laura: regular disposition meetings have been working well for us – experts from around the state come together and problem solve, thinking outside box about what to do – even combine staff from diff organizations to provide service • Susan: maybe want to think about how to continue conversations among different parts of the system. What is working now? What we want to enhance? • Rena: also important is getting voice of families involved – when in the middle of the crisis how do you know about it? • Susan: funding family support person is in grant. Also peer support. But really agreed family voice has to drive. • Sarah: how do we pull in 911 and branch out and train other systems in place. Know to call 911. • Susan: 911 have to have training and ability to call 988 number • Naoimmy Baret (PSNRI): think about taking advantage of ride along that already exists, and community policing. Also using community providers that are already doing that work to promote SPoA • Shannon: while talking about some of the connections, work with family and the mom is on the board of RI association for infant MH, has been pretty active advocate for making health and safety issues aware to children with disabilities. If we're talking about parent involvement, what if we reached out to some of our parents – this mom might be really helpful advocate, has even done commercials. Would that be a way to branch out and make 988 number better known.

		• Susan: education of population is going to be huge. Anticipate 988 be operational by July, but will not be highly advertised yet so that can build capacity. Marketing might come up at later date than when we start. • Naiommy Baret: Becky is family partner on board, part of a lot of the workgroups, at Bradley, been to family advisory committees, she's a strong voice. Good idea to use who's already there and outreaching to them. Really want to reach out to family partners and have them present in these conversations and we have to use who we have. • Susan: needs to know what families need. How should families enter and what should be their experience? Families should know how to enter, should be seamless, services to meet their needs at the other end. • Sarah: crisis defined by family
Screening		• What is occurring now in terms of screening and assessment? (behav health providers, pediatricians, schools) • Susan: pediatric symptom checklist • Naoimmy: SBIRT (Screening, Brief Intervention, and Referral to Treatment) - I used to use it. Were trying to expand it – assessing what supports families need overall • Marti: when we applied with SBIRT was mostly for adults, but application to include youth was way to complicated, talked to RISAS folks instead and tried to align • Sarah: doing SDOH screening built into EMR • Susan: what should we be screening for? Behavioral health, suicide risk, ACES, SDOH • Sarah: need to learn about trauma response not just what trauma's happened when thinking about BH (exposure one thing, symptomology is another) • Marti: how to make sure not double copays if saw two providers in one day. Maria Tumber at OHIC could be person to ask about sceening • Kayla: PSE 17 is what we use, it's short but gives little clinical info. Use UCLA PTSD index for ACES which gets at exposure and response. • Kayla: screenings around parenting, family rejection and acceptance, some of those might be helpful, connection to family, friends • Joe Robitaille: as provider doing job of CEDAR – field people calling and determine if the service is right for them. Maybe SPoA needs to understand services best and do work of figuring out if service matches. • Shannon: from CEDAR used to have point person to fall back on who stayed with family throughout treatment – she often

		gives families the list of services and would be helpful to have that in one place • Marcia Tryon: in MA have ICC in centers in various regional districts of MA – know providers in area for different levels of care, coordinators stick with them. Prioritizes family voice, family choice, use wraparound model. • Susan: we have that but only for limited population, big gap is they haven't been trained to understand IDD, some of the functions from CEDAR brought back under medicaid. They understood AVA's and everything for that population. • Naoimmy: At parent support network have community health workers, peer recovery specialists, etc to support youth w BH, MH, etc, we support them and get parent partner with lived experience. State wide family care network – support at different levels with these various ppl. • Susan: I think we have family support partners in FCCPs, not sure if that's in PRN model but do have that • Susan: any other thoughts? • Marti: thank you for all of the work, bringing this all together into a very specific plan
Closing remarks, next steps		• There's 8 workgroups, next step is to bring it all together and update SOC plan for CBH • Will distribute to outside stakeholders for outside review – aiming for that to happen in September. Overall plan and then also what workgroups contributed. • Moving forward would like to maintain group, cadence might look different but will reach out about next steps.
Chat		Shannon Ciccone to Everyone (3:33 PM) Yes this is great **in response to MRSS slide** Sarah Kelly Palmer (she, her) to Everyone (3:52 PM) Great point Rena. **to finance model** hsachs to Everyone (4:03 PM) My apologies, I will have to sign off. Great discussion. Cindy M Gordon (she/her/hers) to Everyone (4:07 PM) Naiommy is raising her hand Kayla David she/her to Everyone (4:13 PM) we are using it at FSRI and we are partnering with Providence Community Health Centers to provide SBIRT Screening there as well Me to Everyone (4:18 PM) Does the SPOA also refer to other services beyond BH like for housing, clothing, other family needs? Because if screening for SDOH prob also want to have ways to connect people with their needs Emily Matthews-FSRI to Everyone (4:27 PM) They do.