The Children's Cabinet
Monday, December 5, 2016
DOA Conference - Room A
10:00 a.m. – 11:40 a.m.
Meeting Minutes
APPROVED 1/30/2017

Members in Attendance: Elizabeth Roberts, Chair; Rebecca Boss; Michael DiBiase; Melba Depena; Jennifer Griffith; Scott Jensen; Jim Purcell; Nicole Alexander Scott, MD. **Absent**: The Honorable Gina Raimondo; Ken Wagner; Jamia McDonald.

❖ **Call to Order and Agenda Overview:**

Secretary Roberts called the meeting to order and thanked everyone for attending. The Secretary asked for a motion to approve the minutes from the October 31st meeting. Director Jensen made a motion to approve and Commissioner Purcell made a second motion. Secretary asked the Cabinet if there were any comments or amendments to be made to the minutes. There were none. Secretary asked all those in favor of adopting the minutes, all were in favor, 0 opposed. Motion passed and minutes were adopted.

Secretary Roberts reported that today's meeting will be focused on the Cabinets ongoing discussion regarding children's behavioral health. This discussion was started by reviewing findings outlined in the Truven Report, which concluded that children in RI face greater economic, social and familial risks for developing mental health and substance abuse disorders than children in other New England states and the nation. Truven's recommendations included looking at social and economic risk factors to reduce risk, building responsive program models, and implementing a population health approach to addressing children's behavioral health state-wide. The Secretary thanked Dr. Alexander Scott for her continued leadership on population health focus that is broad and encompassing, and our SIM effort is doing the same and we want to make sure children's behavioral health is looked at statewide in an effective way.

At the August meeting, we discussed how we are collectively working to implement strategies in line with these recommendations across this agencies represented on this Cabinet – whether through DOH's development of population health goals and strategies, DHS and DLT's efforts to get parents back to work, or the SIM's efforts to incubate and fund responsive program models like the child psychiatry access program to strengthen our state-funded service array and the workforce that supports it.

We have heard directly from young people, school nurses, and parent and child advocates regarding gaps in coverage, difficulty finding appropriate services, and a need for a more coordinated approach state-wide to supporting children's behavioral health. For us to get there, I think we've all realized the importance of working from the same sheet of paper – at our September meeting, we looked at the shared system values that other states have adopted to underpin a state wide approach to children's behavioral health, and worked to develop shared system definitions.

Today we will hear from members of the Youth Sub-Committee of the Governor's Council on Behavioral Health. They have discussed the issue of system values and needs with their members, and prepared a series of recommendations for us to consider as we continue to examine this system. After hearing from the youth sub-committee, we will review data collected by Providence Plan regarding our state-funded Children's Behavioral Health service array, before discussing potential next steps for our cross-agency children's behavioral health work team. Members of the team have met with the Providence Plan to look at our current service array, and in light of the many items we have discussed thus far, I'd like to begin brainstorming as a Cabinet about the action plans and additional research we'd like our staff to embark on next.

We do not need to decide our next steps today, especially as I'd like to make sure that we hear from members who are not present today before we do so, but I'd like to start narrowing in on a handful of initiatives that our team can dig into more deeply and develop scopes of work around. Clearly we also want to hear from our partners who are joining us today and who have joined us consistently over the last several months around this topic.

Secretary Roberts introduced Anne Mulready, the chair of the Youth Sub-Committee of the Governor's Behavioral Health Council.

❖ **Governor's Council on Behavioral Health – Sub Committee on Youth**

Anne Mulready reported that the Youth Sub-Cabinet Committee of the Governor's Behavioral Health Council was formed approximately eight years ago in response to concerns in the children's behavioral health system. A report was issued in 2012 about what was working or not working in the system and recently the committee became rejuvenated through a BHDDH Healthy Transitions Grant from SAMHSA. The grant is focused on youth and young adults between age 16 and 25 which looks at innovative models of service provision for that population that grew out of a psychosis research model. The federal government wanted to promote that model and look at its utility for other populations. It offers the youth a menu of services, and talks about how employment and education are every bit as important as any of the clinical findings that the project has to offer.

Anne gave a summary of lessons learned through the stories that were recently collected about youth in the system from several different sources that illustrate some common themes around barriers with transition issues and mental health needs.

The following themes identified in the stories are as follows:

- Need for transition planning in the children and adult system
- Lack of housing options, including supportive housing for this age group
- Need for new models of treatment that are accessible, affordable, community based
- Need for better public awareness and training regarding both the clinical needs and service needs

The following are several recommendations with respect to transition:

- Issue: State law now mandates BHDDH and DCYF initiate transition planning 12 months prior to the youth's 21st birthday, however, it did not routinely happen according to the youth stories they encountered.

  Recommendation: Create a uniform referral process between BHDDH and DCYF so that one liaison in each department handle all referrals between the systems, and publicize that process so people know how to access it.

  Also start the transition planning sooner, as the Prevention of Sex Trafficking and Strengthening Families Act requires transition planning for youth out of home and in DCYF care start at age 14. It would be ideal to mesh those processes together.

  Ensure that transition processes support both youth who will be eligible for adult services who will meet the definition of Serious and Persistent Mental Illness (SPMI) as well as those who currently identify as Seriously Emotionally Disturbed (SED), but who do not meet the SPMI definition which is BHDDH's core priority population.

Secretary Roberts asked Anne how the transition works for those youth who are served by DCYF who don't meet that standard, what is the impact for those young people and how are they supported in the system going forward. It appears that there is a broader scope in DCYF than we have at BHDDH, what is the scale of that and what is the impact.

Anne Mulready stated that those youth who identify as Seriously Emotionally Disturbed but don't meet the SPMI standard, still have access to clinical services, but are probably missing in that critical transition age is the case management and support. The adult Community Support Program for the SPMI population have that case management support.

Acting Director Boss added that the transition process as it currently exist is such that when a youth is nearing the age that they are going to depart from DCYF, which is 21 if they are engaged in services, twelve months prior to their 21st birthday there is an application process and it is submitted to BHDDH, however, unlike Developmental Disabilities, we don't have social workers that are assigned to the case. All of the services are provided in the

community, therefore if an individual looks like they will need the support for Serious and Persistent Mental Illness (SPMI), which is what SED often turns into on the adult side, then the referral is made to a community mental health center. The referral is reviewed and evaluated to determine whether the individual meets SPMI criteria, so whether or not the SED diagnosis turns into SPMI which then qualifies the individual for the integrated health home program that provides wraparound case management support for many of these individuals. It's also whether or not it turns into a group home placement, because housing is an issue. All of those services could be there for that individual that meets that criteria, but if they don't, there are problems of access to the other wraparound services, that's really gap in the continuum as well as the housing. Rebecca stated that she does not hear often that there are problems with the application process as BHDDH and DCYF work together and referrals are made; however it may be the few individuals that fall into that gap, where the DCYF case was closed before the age of 18 and a referral was made afterward, but not before the twelve month time frame of before the age of 21. It's not so much the process as it is where we have those gaps and youth not able to be served.

Commissioner Purcell inquired as to how different the definition is of what is disabling for a youth versus what is disabling for an adult.

Anne Mulready stated that the SED definition is based on a need for services and a diagnosis that falls within the Diagnostic and Statistical Manual of Mental Disorders (DSM), that is not true for the adult system, it is a much narrower diagnostic definition, as well as a significant treatment history in the person's background using higher level of services.

Secretary Roberts inquired as to how many people under 21 who are in DCYF services transition into the adult system and what proportion don't.

Director DiBiase stated he was unclear about what is missing in the gap of people who don't qualify for the BHDDH SPMI, as they still receive Medicaid and other medical services.

Anne Mulready stated that while they may have clinical access, what is missing is the case management in some of the wraparound supports as people at that age do not have independent living skills, they may not have resources for housing, barriers to working and school.

Brenda Amodei of BHDDH added that not all of the young people that need that level of care in the adult system are necessarily transitioning out of state care. We are fortunate to have the Healthy Transitions Grant because that is who we are able to serve and we are not at a loss for having people meet our eligibility criteria.

Secretary Roberts inquired as to whether the grant is expanding who we are serving in the transition, and if so how are we supporting them once they get into the adult system.

Brenda Amodei stated that the grant is in the adult system and what they want to try and do through the model that Anne mentioned, is have a way to pay for it after the grant expires, because right now there is no other mechanism to pay for that type of treatment, because they don't meet the definition of SPMI.

Secretary Roberts clarified that the people that do not fit the qualification are being supported by an expanded level of service through the grant.

Brenda Amodei concurred and stated that it is a three year grant for two communities and is a temporary measure to assess the impact. Brenda added that even what is available for the general adult population that meet the criteria for SPMI, isn't necessarily a fit for this age group. Young adults and 16-25 coming into our system as older adolescents have their own needs and much more career focused. It's not just a maintenance type of program, and the supports even look different. They need family support, and the adult system does not have the type of family involved as you would find in the children's system. We want to take the good things that happen while they are in the children's services and bring them into the adult system.

Dacia Read added that the Cabinet may want to think about doing an interagency lean process that would bring the data into the conversation, because it's not just DCYF data, it may also include Medicaid data, and may even a few other agencies to find data on the population need.

Secretary Roberts concurred and asked Anne to continue her presentation.

Anne Mulready stated that Council's next recommendation concerns housing, and almost all of the youth that participated in telling their stories, lacked stable housing. The young adult population still need some type of transitional or permanent supportive housing. Anne stated they were hopeful in exploring a set aside of funding for housing for this population, perhaps through the recent housing bond funds that may contain anything that would fit the model. Many of the youth are homeless but they will not fit the homeless definition for HUD, so they are left out. Housing is so essential for their stability and their ability to take advantage of the clinical services, employment support services, or educational services. Anne stated that the Healthy Transition pilot shows promise for the array of service models for the group, which is very centered and recognizes that education and employment supports are essential and hopefully will change the trajectory for the youth.

Anne also added that the stories they collected pointed out the need for public education, in addition to developing specific treatment programs and to publicize and educate the community both about the symptoms that youth are experiencing where sometimes the symptoms are mistaken by first responders, court personnel, and by others.

In closing, Anne commented on the need for infrastructure support for community based services and care coordination, such as the former Child Adolescents Services Program (CASP) model from the 1990's which in addition to providing flexible funding, it also supported an infrastructure for planning that was locally based at the community level and it brought together an interdisciplinary group of individuals. It was a place where schools could refer people as well as a place to do some individualized planning.

Secretary Roberts added that she had participated in that program in a former position and it consisted of community based partners, families, professionals, and others developing sometimes non-traditional specific service arrays for kids in the community. The Secretary assed that the Family Care Community Partnership (FCCP) took over the CASP role and is a DCYF based, and asked Ben Lessing to provide more background on the FCCP role.

Ben Lessing stated that the FCCP is an integration of what DCYF formerly used as preventative services called Comprehensive Emergency Services and was combined with CASP. CASP theoretically never went away, in fact the Department invested in the High Fidelity Wraparound which was the foundation model of the CASP system and Wraparound that has occurred in other states as well. However, part of the problem that has occurred is the infrastructure for behavioral health for kids at DCYF has diminished over the last decade, therefore the robust emphasis on CASP of 15-20 years ago is no longer there in the same way. The framework is still intact, but there has not been, particularly in the last few years, a lot of follow up in making sure that its being implemented as it should.

Secretary Roberts stated that in the absence of Jamia, she wanted to clarify that the FCCP has a broader focus than behavioral health, so the services being discussed are anchored in the behavioral health division at DCYF, and one of the issues here is that division has been less of an entity than it had been in the past with less visibility.

Ben stated that both the preventative services and behavioral services were supposed to be part of the Children's Behavioral Health Division at DCYF. It was an effort to really integrate both of those intensive preventative services as well as CASP.

Secretary Roberts thanked Anne for her presentation, and turned the meeting Katheryn Tavares of Adoption Rhode Island and member of the Healthy Youth Transitions Sub Committee to give additional background about the grant.

Katheryn Tavares stated that Healthy Youth Transitions is a federally funded program looking at planning and coordination for youth and young adults between children's behavioral health and adult mental health systems. Approximately two years ago, Adoption Rhode Island started an initiative called "Bridges to Hope" which looks at meeting the needs of youth who age out of the foster care system or who experience a disruption to their adoption, guardianship or other permanent living arrangement. Through that initiative they have brought together state agencies, community providers and youth in the foster care system to look at how to better coordinate care, data sharing information and better use of existing resources or tapping into new resources in order to bridge the systems

and services that meet the needs of children and families with the systems and services that meet the needs of adults to bring them together in order for youth to experience a better transition between the two systems.

Katheryn stated they worked with the Healthy Youth Transitions Committee to put together a "Values Rubric" to identify and provide a framework for providers, advocates, funders and state agencies to develop a system of care that is competent in meeting all the needs of this unique population of transition age youth. Through that process they identified key values or competencies and reviewed them as what they would look like at a provider level, state agency level, as well as the funder levels to implement that value or service.

Katheryn highlighted a few of the key values that are more unique and specific to this population:

- Active Youth Engagement – where the young people are equal partners in the development of their case planning, treatment planning, and are able to participate in challenging experiences and have the necessary support to help them succeed in that.
    - At a provider/direct service level, youth are able to advise and influence policy and practice at the provider level and are also given the support and resources they need in order to do that, such as compensation for their time, transportation assistance, meeting times that are convenient, and being reimbursed for their time and effort in creating agency policies or influencing program development.
    - At the state policy level, it means that youth and young adults that have lived experience have the opportunity to provide their feedback, experience, expertise in developing or reviewing state policies in regards to this population.
    - At the payer level where funders are collecting both qualitative and quantitative data from people being served in order to asses gaps in services and that funding supports the integration of the consumer/constituent voice into policy and practice across the state.

- Services that are Developmentally Appropriate – Particularly to this population, it means understanding what is happening biologically in brain development and the developmental life cycle of transition age youth in that there isn't a clear cut line of when you're an adult or not a child anymore. It's a process that happens over years, as the brain and the developmental needs of young adults continues to change well into their twenties. Therefore developing practices, policies and looking at funding structures that support a service delivery that is appropriate to where a youth becomes an adult developmentally – both in terms of being a transition age youth or young adult, and where the young person is individually in their development, so we are not just looking at their chronological age.
    - At a provider level, this would allow for flexibility in their practice to take into consideration the developmental needs of the constituents rather than creating programming eligibility strictly on age.
    - At a state policy level, it means, that policy practices allow access to services and integration of systems serving both youth and adults in order to holistically meet the needs of this population.
    - At a funding level, it allows for flexibility and use of funds to meet the needs of transition rather than segmenting funding for services based strictly on age.

- Using a Family Centered Care Approach
    - At a practice level, it means staff working together with the individuals and families or whomever the individual identifies as their key stakeholder, in order to make choices around where, when and how they receive services.
    - At a funding level, it's allowing to fund strategies such as the money following the person, whereas the individual's needs are identified and the funding is flexible enough to follow them and offer access to those services.

Katheryn stated that while they try to be as comprehensive as possible, by no means, is exhaustive, particularly when looking at the broad brush of transition aged youth and their needs. Clearly there are other competencies and

models that need to be taken into account when looking into segments about population such as LGBTQ youth, housing needs of transition aged youth, or pregnant or parenting youth as well.

Secretary Roberts thanked Katheryn for her presentation, and asked that she and Anne Mulready forward their information to Dacia Read to it may be circulated to the Cabinet for consideration. The Secretary turned the meeting to Dacia Read.

❖ **Children's Behavioral Health Systems Scan Data**

Dacia reported that they have been looking at this issue from a few different perspectives, such as system values, system issues that are state driven, coverage gaps and things that are not necessarily in the role of the state as much as other private insurance carriers or having service arrays that are responsive in the workforces in Rhode Island. This is a multi-dimensional issue that we have been working with the Providence Plan and the DataSpark team to do a deep dive into state funded services and programs that our agencies are currently implementing. We have behavioral health services in our schools, we have them funded through Medicaid, and we have different approaches to prevention, intervention or different types of treatment that are funded across multiple agencies. Dacia stated that system scan has come back and we will review the first round of data from that scan, and would like to get the feedback from the Cabinet as well as the partners in the room to discuss some potential next steps.

Dacia reviewed the Defining System Terms that the Cabinet had agreed upon in previous conversations.

Defining System Terms

- **Population Health**:
  - Physical and behavioral health of the population.
- **Children's Behavioral Health**:
  - Mental health and substance abuse of children ages 0-21.
- **Children's Behavioral Health Services:**
  - Prevention, residential and community-based treatment, and other community-based, social-emotional supports.

Findings and Overview of the System Scan

- This analysis identified 92 distinct programs/services administered through 5 state agencies - BHDDH, DCYF, DOH, Medicaid, RIDE.
- The majority of programs provide direct treatment (38, or 41.3% of all programs)
- Followed closely by support services (35, or 38.0% of all programs).
- 5 programs (5.4%) are focused on prevention and 5 (5.4%) are focused on screening
- All 5 prevention programs are substance use programs (2 general substance use, 2 alcohol/tobacco, 1 marijuana).

System Scan Definitions

Program Type:
- Prevention
- Screening
- Support
- Promotion
- Treatment
- Crisis

Behavioral Health Focus:
- Substance Use
- General MH
- SMI-SPMI
- Emotional Disturbance
- Trauma
- Family Supports
- Life Skills
- Crisis Response

System Scan – Findings - Age Ranges

Among the 86 programs that provided information on eligible age range:
- 47 programs serve 0-7 year olds

- 57 programs serve 8-15 year olds
- 79 programs serve 16-24 year olds
- 40 programs are available to children across all three age categories.

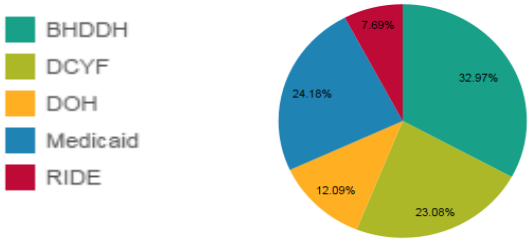
These age categories are not mutually exclusive, and many programs serve a range of ages that covers more than one of these categories.

System Scan – Findings - Geography

While many programs don't have specific geographic eligibility requirements, the location of the provider(s) may limit access.

- 14 programs (15.2%) were identified to be limited by only being offered in one, or a few geographical locations
- 9 programs (9.8%) were only available to children, youth, or families belonging to specific communities, municipalities, or schools
- The remaining 69 programs (75.0%) have no apparent geographical limitations on access

Dacia reviewed the breakdown of Children's Behavioral Health Programs by Overseeing State Agency:



Dacia reported that Medicaid has a large portion, and even though we tend to think of BHDDH and DCYF in children's behavioral health, DOH and RIDE both have programs as well. In regard to the RIDE, some of the things identified were funding and supporting programs, such as promoting social emotional learning in schools. This could translate into a series of different preventions or activities across the different LEA's, but when we look at it from a state specific RIDE program, it tends to look smaller here compared to other agencies.

Secretary Roberts inquired as to how we are defining "overseeing", assuming for example that Medicaid funds many of these services.

Dacia stated that term "overseeing" is described as either administering a program by funding or by implementing.

Director DiBiase inquired as to whether Medicaid actually provided program administration.

Dacia stated that we buy certain services through Medicaid and then they are administered by the providers.

Secretary Roberts stated that one of the issues, is that Medicaid may not the appropriate place, but at this moment it is the place where a lot of these decisions are made, and then we delegate a lot of that to the managed care organizations, i.e. Neighborhood Health Plan and Untied Health, etc. Then we have some issues where we have a three to five year grant to do something and it does not get fully integrated into the service array and financial support, therefore we end up with shifting approaches.

Director DiBiase stated that he looks at our Medicaid operation as the core of it determining eligibility and threshold accountability for the programs, and he does not see its value in maximizing the value of those programs, but rather making sure those programs are delivering enough so they can qualify for Medicaid benefits. Director DiBiase stated that he could be wrong, but that is how he views the Medicaid function.

Secretary Roberts stated that it is an interesting question of whether it's the infrastructure that underpins and part of what we are pointing out here is that we have some gaps and governance in decision making that have lingered

for a while. There is also education which is funded by Medicaid dollars but not through Medicaid policy setting, and it is a very complex environment, having almost 90 providers in a state our size adds to that complexity.

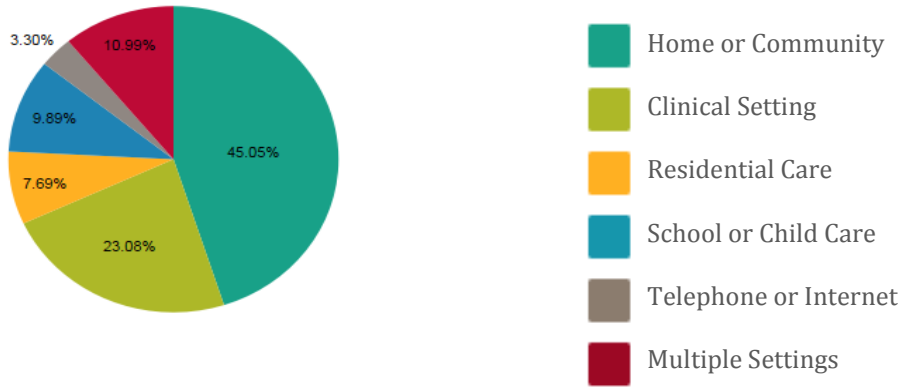
Dacia added that it gets more complex when we look at Medicaid as an insurance carrier paying for certain things and private insurers are paying for certain things, and then we as a state are administering, implementing or paying for certain things. This is a very complex issue, but thanks to DataSpark we can now see it in a different way than we could see before and has unearthed a series of really good questions.

Dacia continued the discussion on the DataSpark survey, which is broken down by agency and behavioral health focus.

Children's Behavioral Health Program Focus by Department

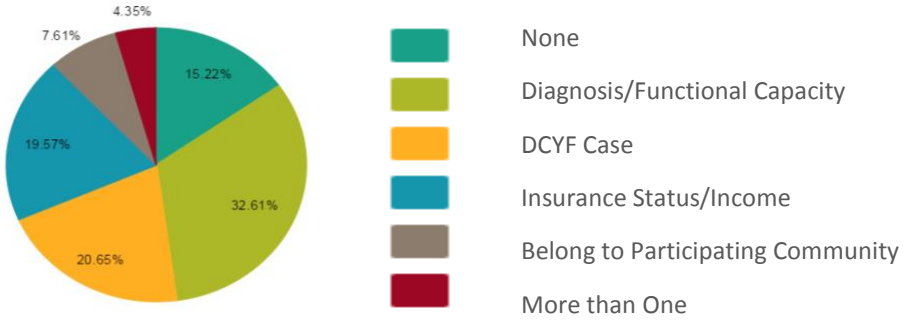
	State Agency				
BH Focus	BHDDH	DCYF	DOH	Medicaid	RIDE
Crisis Response			1	2	
Emotional Disturbance/Trauma		5	1		
Family Support	1	10	2		
General MH	1	4		20	
Life Skills	4	2	4		8
SMI/SPMI	3				
Substance Use	21		3		

Breakdown of Children's Behavioral Health Programs by Service Delivery Setting



What's encouraging when looking at this, is that a lot of our service delivery is in the home and community based setting which is big goal for the Governor around rebalancing services and investing in home and community based services.

Breakdown of Children's Behavioral Health Program Eligibility Requirements



Dacia reported that in looking at the system issues a lot of people have brought to our attention over time, is the question of what do you have to be eligible for and enrolled in to actually access the service. Do you have to have a diagnosis? Is it dependent on your income status if you can access this program? Do you have to be DCYF involved? This is another piece of thinking about how accessible services are based on the different types of eligibility requirements that are attached to those programs.

DataSpark System Scan – Recommendations

Dacia discussed the feedback from DataSpark and their experience in mapping this process:

1. While they were able to obtain information on the number of children or families served and the cost of administering services for some programs, the data was not complete enough to report on or draw conclusions from.
    - A deeper dive into total numbers served, utilization of services, and dollars spent using Medicaid claims data and clarifying a distinct period of time (FY2015 or earlier to ensure complete data) is recommended.

2. This analysis investigated broadly factors that may affect access to services, such as eligibility by age, insurance status, DCYF involvement, or geography. This analysis demonstrated that many of the behavioral health programs available to children require that child to be a Medicaid recipient, be enrolled in DCYF, or have a behavioral health diagnosis, each of which may pose barriers to access.
    - A deeper investigation into processes for referral/enrollment, limitations based on program availability and waitlists, and coordination of services between programs and other care providers would be necessary to better understand and identify barriers to access. An investigation of this sort would benefit from a mixed-methods approach.

3. From these data, it seems that many investments are going toward home and community based care, compared to more costly institutional or hospital settings.
    - An analysis of costs broken down by service delivery setting, or tracking individual patients to see if receiving services in the home and community results in decreased utilization of more costly services would uncover whether these investments are paying off.

Dacia added that there are a few items that the Cabinet has discussed over the last several months on where we can focus our attention next now that we have a stronger understanding of the complexity of the issues involved here and also the distinctions between what's in the realm of state government versus what's in the realm of community, local or other private insurance carrier supports. Dacia discussed the following next steps.

Brainstorm – Next Steps

- Development of recommendations related to leveraging Medicaid-match in schools to deliver school-based mental health services?

- Cross-agency Lean Kaizan event to address children's mental health transitions between DCYF and BHDDH?

- Partnership with OHIC to explore issues related to children's mental health parity through their upcoming market conduct examination?

- Further service system review focused on cross-agency approaches to maintaining a responsive continuum of care for adolescents and young adults?

Dacia stated that she is open to hear more ideas and between this meeting and the next meeting, she would like to get a sense of how we can give the cross agency team a few specific items to do a deeper dive and get back to this group with next steps.

Secretary Roberts added that an issue she would like to look at is system related and to look at the array of providers and where do we have such complexities and perhaps gaps in the system, and trying to figure out the structures themselves. The other issue is about outcomes; can we measure school success, can we measure employment status, and measure things that give us a sense of whether all of this is actually accomplishing its goals. The Secretary is concerned that we have a lot of system definition without a lot of outcome definition for how the young people we are serving are succeeding or not.

The Secretary opened the meeting to the Cabinet and the public for their comments and suggestions in regard to any issues they think need attention.

Acting Director Boss added in regard to the discussion around getting insurance for Medicaid match in schools, that is a conversation that BHDDH has had often as they provide services in schools for student assistance counseling, and other entities. The issue has always been a little complicated as some of those programs provide services to children and there is no access to the parent's insurance information, so we need to think through those things as we have these discussions and figure out the best way to keep access open. In terms of the Lean Kaizan event, she is concerned that it would be focused solely on the application process which doesn't seem to be broken as far as she understands, but rather take a look at the broader issues of those kids that aren't necessarily being referred because they don't think they will meet that level of care and then how we connect to services from there. And finally, the levels of care and the gaps in the system that we aren't able to meet as well as the lack of availability in certain levels of care that don't exist in both the youth and the adult system.

Director DiBiase added that we know we have a lot of children who are not mentally healthy, and he would like to hear from the providers in the audience about whether the State is investing enough in this area compared to other states, are there issues around access, are there issues around coordination, and what is the highest priority that we should be working on?

Dr. Alexander Scott commented on how do we make sure the system is confluent for the clinical care coverage from acute to sub-acute to chronic behavioral health care clinically as well as being able to cover that from a reimbursement and insurance standpoint adequately in connection with OHIC building off of the market conduct. The information that DataSpark addressed can be beneficial in taking the next steps to close the gaps.

Dr. Patricia Flanagan of Lifespan stated this is an incredible step forward and inquired about thinking of high level things across Medicaid funded services, are there one or two things we could measure and have collective impact . We are still talking about children with mental illness, we are not talking about mental health, intervening with young families who are stressed and support them prior to a diagnosis of mental illness. We know enough of what puts families at risk, and we do know of some evidenced based programs that help support young families. There are children living in households who often have parents that have mental health illness themselves that is not addressed, or have other stressers that really make them less able to attend to the needs of their kids. There are consequences to our very stressed young families that are not getting the support they need. It's hard because it's not just the medical system it is a much broader system that we need to look at how we support families. Almost forty percent of the kids in Providence live in poverty and twenty percent are living in families of four making $12,000 per year. It's not that poverty equals mental illness in kids at all, but if we want to be preventative and think about raising strong healthy kids, we need to support family as well.

Secretary Roberts added that we should look at some models of success from other states and see if there is a way that any fit for Rhode Island. One of the challenges we have is that we have 90 agencies involved and how do we maximize what that investment is doing and make sure its meeting our needs.

Dr. Flanagan stated that the transition of children from DCYF to adult care is really important work, but we also need to keep our mind on the foundation of a lot of the issues we are dealing with is much broader. There are successful models around that especially start to integrate this level of support. One model that supports families with what they need, not what they are eligible for is the Vermont Integrated Family Services.

Ron Seifer of Bradley Hospital stated that the data presentation was a scan of the programs and a few people have noted the need for child centered, family centered approaches. Knowing the incredibly complicated matrix of 90 programs in the public sector and how many added private sector, that really needs to be complimented by the child centered view of looking at how many hundred thousand children there are in Rhode Island, how many are doing well, how many are being served and having good outcomes, how many are served and having poor outcomes, and how many are not getting served at all. Until we do our data processing at that child/family level and have that complimentary view, we are going to spin wheels on how to put the 90 programs together to best serve families.

Secretary Roberts inquired as to how much information Kids Count data would have available to us and how much would be missing.

Ron stated there may be small analysis that could be done within specific communities, within specific age ranges, but will be harder to do than the program analysis, because they have all the administrative information for the program data. Until we understand the needs of families of who's getting what they need and who is not, and how they are interacting with the 90 programs we don't really have the answer.

John Farley of Family Service Rhode Island added what is troubling, is that the various number of doors we have open is a good thing on one level, but a bad thing on another level because we don't understand what the eligibility criteria are across the board, there is no standardization in any way of the ability to determine what the level of need is. There is a need to more appropriately consolidate the identification of the population and then assess what the need is in a more consolidated way.

Stephen Buka of Brown University underscored a discussion from a prior meeting in regard to readiness by 3rd grade and the value of a statewide birth cohort. While the stressors that may result in the need for psychiatric services can occur anytime in life, the vulnerabilities are largely established early on in life. There is great value in building on the universal information that we have starting with KidsNet and beginning to document over time what happens to kids in terms of service receipt and child / family needs. It would be good to know the needs and the status of all kids from ages 0-21, but that would be a monumental task. Starting with birth cohorts and moving forward would not be such a difficult undertaking and would address the emphasis on third grade readiness and the questions about need for and receipt of mental health services currently under discussion.

Brother Michael Reis from Tides suggested that there be a focus on the population of the severe families with mental health issues. This group is notorious for not cooperating and not trusting anyone in the system. All of the behavioral health programs are based on the person cooperating and attending meetings, however, if this population does not get the proper guidance, they will not get the help and they will get bounced out of the programs and go to jail. Brother Michael stated that this population responds well when they are visited in person, but when you just put it in a medical plan, they will not show up and they ultimately get knocked out of the system.

Lisa Guillette of Foster Forward added that she does not believe there is enough infrastructure for the transition aged youth and does not think we have developed a system that recognizes the fact that the adolescent brain development takes us well into the mid 20's. We have used Medicaid funding, but it is not the solution. An infrastructure flexibly using Medicaid on top of it, could work. Lisa stated that the YESS Program serves youth who have aged out of DCYF care, and some participants with sex offender status cannot safely go to open market apartments and live on their own, they need some kind of supervision. The most flexible place that will take them, unfortunately is the ACI, where they will meet their housing needs, and we need to change that. We have to look at the National Youth in Transition Database (NYTD) data which is a great longitudinal data set that tells us how many of these kids who have experienced DCYF care on or after their 17th birthday have ended up incarcerated, homeless or have become parents. Lisa stated that if we put a little more infrastructure around a flexible transition system for these transition aged youth, we will see cost savings.

Secretary Roberts questioned as to whether we are spending adequately, just not on the right things, not in the right places?

Lisa Guillette stated that she appreciates the Medicaid home stabilization opportunity, but that only works if layered on to an adequate infrastructure. Fortunately our state does have some infrastructure for 18-21 year olds who aged out of foster care where the state is already investing about $1.7 million a year in general revenue dollars to pay for a modicum of basic supports for those young people. Therefore, you could effectively layer a Medicaid reimbursement strategy on top of that, but for the kids who stay in care until they turn 21 who don't qualify for adult services, there is no YESS aftercare to help them navigate that transition. Some kids may have a family structure that is going to support them, while others do not have a permanent adult connection. If they youth is getting to the end of their sentence at the training school, and their history includes abuse in the home, going home may not be an option. We have these subset groups that are costing us a lot of money, and if we did the Lean Kaizan analysis, and looked at those numbers, we could reinvest towards better outcomes. The Kids Count data show there are approximately 100 kids per year who are aging out of foster care, which is the aggregate number of kids who are turning 18 combined with the kids who are 21 because they stayed in for DD or SED. That is where we are spending a lot of the money, and if we could figure some of those issues out, we could change the pipeline to the ACI. The NYTD data will show that some of these kids are going to the ACI. Lisa reported that she signs the checks for the inmate accounts when Foster Forward provides stipends for incarcerated young people who complete surveys, as we survey every youth in foster care within 45 days of their 17th birthday, they are contacted again at 19 years of age and again at the age of 21. The state has the data and it should be analyzed to see where the state is spending its money.

Commissioner Purcell stated Rhode Island has many cities and towns for such a small state and there should be an effort made to consolidate services into regionalized locations in the state. We need to concentrate on how to make this triage process much more efficient so that we can help the people that need it the most.

Lisa Guillette concurred and stated that the former CASP model had eight local coordinating councils made up of seven community mental health centers and the John Hope Settlement House. It was a $15.8 million federal grant, however, when the federal grant expired, over time we didn't make the corresponding investment in our infrastructure to keep it going. It was the right thing to take CASP principles of wraparound services and infuse that into how we are serving families who are coming to DCYF who are entering because of abuse and neglect, but it was watered down and we lost our behavioral health focus.

Ben Lessing of Community Care Alliance suggested to go back to the community as all these issues can be cross-walked to see how they are connected. It is done on a community level, however, we don't see it at the state level. Woonsocket has the highest rate of child abuse and neglect in the state, and we see unemployment and homelessness being major factors. We are trying to attack these problems on our own, but should be doing them in partnership with the state. In terms of the data, all of the programs are aggregated together, but they are not all behavioral health programs, some are child welfare programs, some are early childhood programs, etc. We need to ask the question, do those programs that are not truly behavioral health programs, do they have the capacity to provide what is needed on a behavioral health basis, or are they integrated with something else that can. Ben stated the next step has is to go to the communities and talk to the providers. The providers will give a very clear idea of what is happening and what works. Lastly, from a behavioral health perspective, all of this goes back to the health plans. Several years ago DCYF basically turned over its treatment programs to the health plans and the health plans took them and made what was more a CSP type of program, particularly for those needy kids that needed extended community based treatment, and turned them into an acute program, this is why we see a spike in hospitalizations over the last eight or nine years, you see these kids cycling through these acute programs, then they are moved to outpatient, where outpatient is not sufficiently funded in terms of either rate or case management services, and the cycle starts over again. There may be enough Medicaid funding, the question is whether it is being spent correctly on the right model.

Lisa Conlan Lewis encouraged the Secretary to speak with Sheila Pires, who is a lead coordinator working under the DCYF system of care CMHI Grant. Sheila has worked over the last two decades in financing and is highly knowledgeable around the system of care, frameworks and practice models.

Secretary Roberts asked that Dacia connect with Lisa to reach out to Sheila.

Acting Director Boss reported that BHDDH is in the process of posting an RFI with the Department of Administration that will take a look at centralized crisis assessment and crisis response. This is an adult system, but there is a lot of work going on to do the same type of work in the children's system, and there is a desire to align both processes. Acting Director Boss welcomed any feedback and community input on what type of crises response and assessment is most needed and appropriate in the adult behavioral healthcare system. Acting Director Boss also announced that the State Youth Treatment Planning Grant is in the process of turning into a State Youth Implementation Grant with an application that is due December 20th, and BHDDH is currently looking for letters of commitment from the community in order to submit that grant.

Seccretary Roberts asked if there were any further public comment. There was none.

- **Adjournment**:

Secretary Roberts stated the next Children's Cabinet meeting will be held on Monday, January 30th. The Secretary thanked everyone for attending and asked for a motion to adjourn. Director Jensen made a motion to adjourn, Commissioner Purcell seconded. All were in favor, 0 opposed. The meeting adjourned at 11:40 a.m.