Children's Cabinet

December 15, 2020

RHODE ISLAND
Children's Cabinet

Agenda

- Welcome and Introductions (2 min)
- Vote on adoption of October and November meeting minutes (3 min)
- MIECHV Needs Assessment Presentation (15 min)
- FSRI Multidisciplinary Pilot Presentation (30 min)
- Public Comment (10 min)

ECCE Strategic Plan Adopted in 2020

Mission: Rhode Island's comprehensive focus on Early Childhood Care and Education brings together providers, programs, advocates and families to ensure that our children prenatal through age five have equitable access to high-quality education, health and developmental care, and services and supports needed in order to enter school healthy and ready to succeed.

Vision: All Rhode Island children enter kindergarten educationally, social- emotionally, and developmentally ready to succeed, putting them on a path to read proficiently by 3rd grade.

Objectives:

1. Rhode Island's early childhood programs meet high-quality standards for care and education as defined by our Quality Rating and Improvement System.
2. Children and families can equitably access and participate in the early childhood care, services, and supports that will help them reach their potential and enter school healthy and ready to succeed.
3. All four-year olds in Rhode Island have access to high-quality Pre-K, inclusive of parental choice and student needs.
4. Secure the quality and delivery of ECCE through increased and sustainable funding and operational improvements
5. Expand the depth and quality of family and child-level data accessible to and used by agencies, programs, and partners to drive decisions.


RHODE ISLAND
DEPARTMENT OF HEALTH


ACCREDITED HEALTH DEPARTMENT
PHAB
Advancing public health performance
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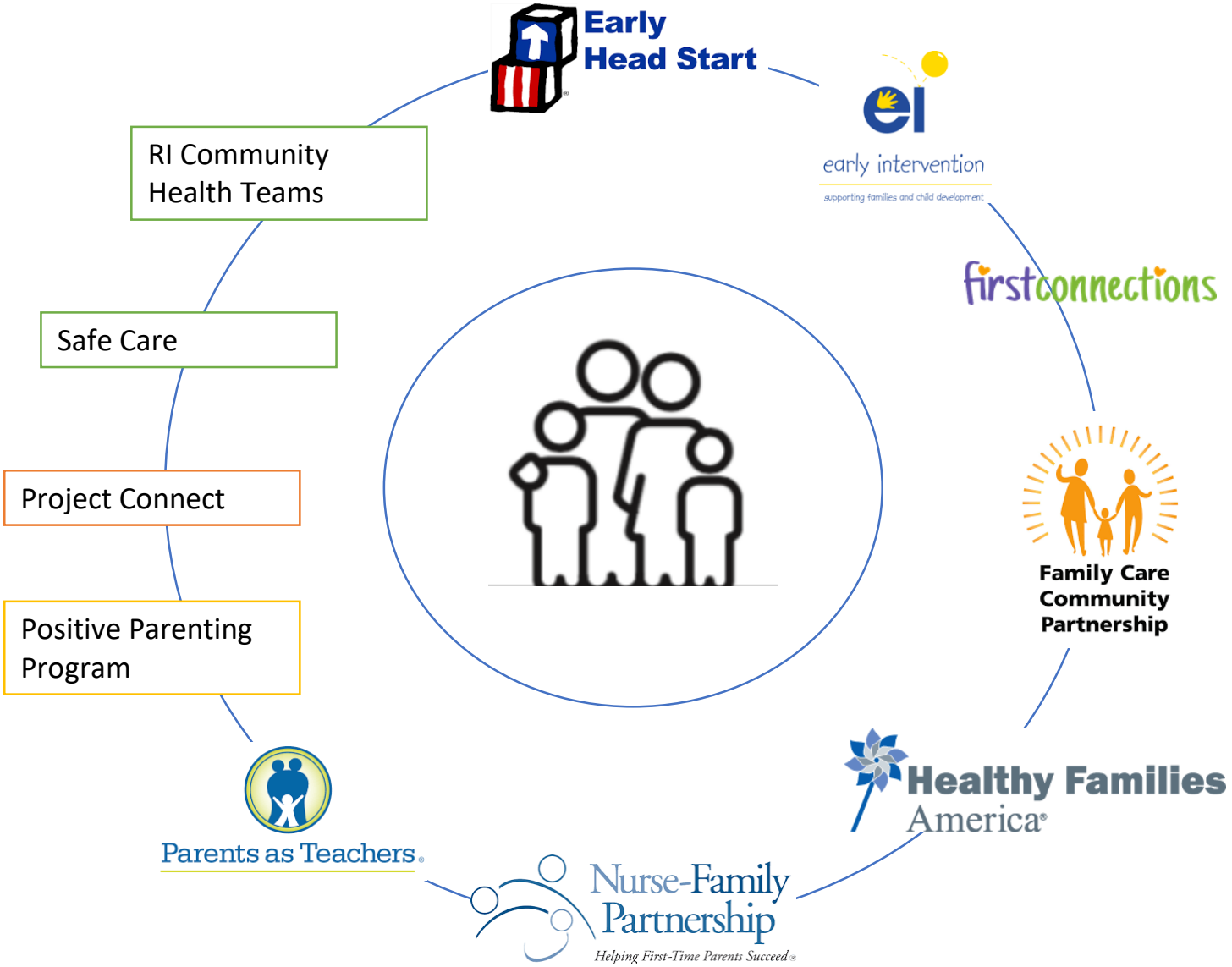
Rhode Island Family Visiting Needs Assessment

Statewide Family Visiting Needs Assessment

- Family Home Visiting grant recipients were required to update their statewide needs assessment **by October 1, 2020.**
- The last update was in 2010.

- **Statutory Requirements**
  - Identify priority communities with concentrations of individual and community-level stressors (including SUD, among others)
  - Identify quality and capacity of existing early childhood home visiting programs in RI
  - Discuss RI's capacity for providing substance use treatment and counseling services
  - Coordinate with other needs assessments (Title V MCH Block Grant, Head Start, and CAPTA)

Rhode Island's Early Childhood Family Visiting System



MIECHV Statewide Needs Assessment

Steps (non-linear):

- Identify priority communities
- Eligible families – calculations
- Inventory of existing programs
- Identify “quality and capacity” of existing programs
- Assess SUD/recovery capacity and need
- Solicit community feedback
- Coordinate with other needs assessments (ongoing)
- Report and share findings (iterative)

Identifying At-Risk Communities

Z-Scores By Domain

City/Town	SES	Adverse Perinatal Outcomes	Substance Use Disorder	Crime	Child Maltreatment	RI Health Equity Indicators	Number of At-Risk Domains
Woonsocket	***1.00***	***0.50***	***1.00***	***1.00***	***1.00***	***0.50***	6
Pawtucket	***1.00***	***1.00***	***1.00***	***1.00***	***1.00***	***0.58***	6
Providence	***1.00***	***1.00***	***1.00***	***1.00***	0.00	***0.67***	5
Central Falls	***1.00***	***0.50***	0.00	***0.50***	***1.00***	0.42	4
West Warwick	0.33	***0.50***	***0.50***	0.00	***1.00***	0.25	3
Newport	0.33	***0.50***	0.00	***0.50***	***1.00***	0.33	3
Warwick	0.00	***0.50***	***1.00***	0.00	0.00	0.17	2
Lincoln	0.00	***0.50***	0.00	***0.50***	0.00	0.09	2
Cranston	0.00	***0.50***	***0.50***	0.00	0.00	0.17	2
North Providence	0.00	***1.00***	0.00	0.00	***1.00***	0.25	2
Washington County	0.00	0.00	0.00	0.00	0.00	0.00	0
Charlestown*	0.33	***1.00***	0.00	0.00	***1.00***	0.09	2

Program Overviews

- **First Connections:** assessment and referral program for children birth to 3.

- **Nurse-Family Partnership:** program focused on improving pregnancy and child health and development outcomes for low-income first-time mothers and their children.

- **Healthy Families America:** program focused on promoting and strengthening positive parent-child relationships, positive growth and development, and building protective factors.

- **Parents As Teachers:** program focused on increasing parent knowledge of early development, preventing child abuse and neglect, and increasing school readiness and success.

Capture Rates and Contracted Capacity

Nurse-Family Partnership, Healthy Families America, Parents as Teachers

City/Town	Contracted Slots	Target Population	2019 Enrollment	% Capture Rate	Contract Slots as % of Target Population	% Contracted Capacity
Woonsocket and Surrounding Areas	174	420	154	**37%**	**41%**	89%
Pawtucket	201	198	169	85%	102%	84%
Providence	579	618	452	73%	94%	78%
Central Falls	110	96	91	95%	115%	83%
West Warwick and Surrounding Areas	114	258	114	**44%**	**44%**	100%
Newport County	146	206	131	64%	71%	90%
Cranston	84	138	84	61%	61%	100%
Washington County	114	152	99	65%	75%	87%
State Wide TOTAL	**1522**	**2086**	**1294**	**62%**	**73%**	**85%**

Source: RIDOH

Capacity Assessment

Contract Area	Nurse-Family Partnership	Healthy Families America	Parents As Teachers
State Wide Assessment	**Increase total contracted slots**	**Reallocate contracted slots**	**Needs largely addressed with PDG funds**
Woonsocket and Surrounding Areas	**Increase contracted capacity**	Focus on increasing capture rate	**Increase contracted capacity**
Pawtucket	Focus on increasing capture rate		Focus on increasing capture rate
Providence			Focus on increasing capture rate
Central Falls			Focus on increasing capture rate
West Warwick and Surrounding Areas	Focus on increasing capture rate	**Increase contracted capacity**	**Increase contracted capacity**
Newport County	**Increase contracted capacity**	Focus on increasing capture rate	**Increase contracted capacity**
Cranston	**Increase contracted capacity**		**Increase contracted capacity**
Washington County	**Increase contracted capacity**	Focus on increasing capture rate	

Quality and Capacity: Areas of Study

- Underserved Populations
- Family Experience
- Cultural Responsiveness
- Need for More Services
- Barriers to Services
- Recruitment, Staffing and Funding

Underserved Populations

- Communities of color
- Families who speak English as a second language
- Southeast Asian population (SEA)
- Adolescent parents
- Families without access to technology

Key Findings: Families' Experience

- Most families feel comfortable with their family visitor
- Virtual visits have had a mixed impact on family engagement across programs

Key Findings: Cultural Responsiveness

- Families need and want a cultural connection with their family visitor (and one that speaks their language).
- Rhode Island needs more interpreters, especially:
  - American Sign Language
  - African Languages

Key Findings: Need for More Services

- Behavioral health clinicians, especially those trained in trauma and postpartum depression
- Safe and affordable housing
- Flexible family visiting options (groups, visits on nights and weekends)

Key Findings: Barriers to Service

- Stigma
- Lack of access to critical social supports:
  - Transportation
  - Childcare
- Access to technology

Key Findings: Recruitment, Staffing and Funding

- Awareness of family visiting is low, especially among womxn of color
- Womxn of color view family visiting with significant mistrust
- Need to expand referrals to family visiting, especially from healthcare providers, and increase brand recognition
- Need more staff with the same cultural and linguistic backgrounds as the families they serve

Key Findings: Recruitment, Staffing and Funding

- Agencies find it hard to hire staff with required credentials and experience
- Staff turnover is a significant challenge (low wages are a driver)
- Need for increased collaboration between family visiting, health and behavioral healthcare providers, substance use treatment providers, and schools
- Funding levels and reimbursement rates make it difficult to cover the cost of family visiting and appropriately compensate family visiting professionals

Maternal Substance Use/Substance Exposed Newborns

- In 2019, there were 10,718 pregnancy admissions of RI residents
- 522 (4.89%) of those women were discharged with a substance use diagnosis (including nicotine)
- Women 15-24 years of age had pregnancy admission with substance use diagnosis at slightly higher rates compared to women age 25 and up
- 67% of pregnancy admissions with a substance use diagnosis are white women
- Seventy-five percent of admissions are covered by Medicaid and 14% are covered by private insurance
- 3.1% of newborns born in RI were prenatally exposed to substances, down from 3.9% in 2017-2018 (Medicaid claims data)

Substance Use and DCYF Involvement

- Approximately half of the families who have infants experiencing NAS are involved with DCYF at hospital discharge
- 70% of NAS infants are discharged home with their biological parent(s) and 30% are placed in foster care
- All NAS infants are referred to First Connections

System Gaps

- Not enough residential treatment beds for the whole family
- Need to increase screening and identification of SUD
- Need for more peer recovery coaches for pregnant and postpartum parents with SUD
- Need recovery housing for families
- Need to continue professional development and training on maternal substance use and substance exposed children for frontline staff

System Gaps (Cont'd)

- Need to develop and disseminate a policy statement that will help to inform messaging to families about the danger of marijuana use during pregnancy
- Need more care coordination and communication between medical providers and behavioral health providers
- Not enough access to long-term recovery supports
- Not enough access to safe and affordable housing
- Not enough access to sustainable employment opportunities

Barriers

- Not enough access to critical social supports:
  - Transportation
  - Child care
  - Legal/Court Services
- Negative perceptions and fear of DCYF
- COVID-19 crisis

Opportunities for Collaboration: Alignment and Integration of Data

- No single data source for licensed treatment practitioners and providers and detailed information regarding treatment and services available for specialized populations
  - Each agency keeps data separately with varying levels of detail

- Different agencies hold different roles in the system:
  - BHDDH provides licenses to facilities providing mental health services for adults and substance use disorder services for all ages
  - RIDOH provides licenses to independent practitioners and hospitals
  - DCYF provides licenses to mental health providers for children under 18.

- SAMHSA maintains a treatment locator website for each state, the data on this site does not match local data.

Next Steps

- Share results with stakeholders
- Identify next steps and response:
  - Family Visiting Council
  - Local Implementation Teams
  - Alignment Other Needs Assessments
- Reallocated contracted slots
- Continue to advocate for increased funding

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Building Multidisciplinary Teams to Support Families

Presentation & Discussion
Children's Cabinet
December 15, 2020

CARE TRANSFORMATION COLLABORATIVE OF R.I.

Why We Are Here Today

- Share what we are learning from the FSRI Multidisciplinary Team Pilot - a coordinated effort between FSRI's Community Health Team & First Connections program - to **increase coordination, reduce duplication and address gaps in care for families.**

- Talk together about our successes, challenges and work ahead to more effectively provide services and supports to families.

What is the Community Health Team?

CHTs are an Extension of Primary Care

CTC-RI's Community Health Team (CHT) Program serves individuals and families with high-level social and behavioral health needs in order to establish healthier living, and improved health and cost outcomes. CHTs provide in-home, community and office engagement to referred individuals and their families to effectively address:

- Physical health needs
- Behavioral health/ Substance Use Disorder needs
- Health education needs
- Social needs

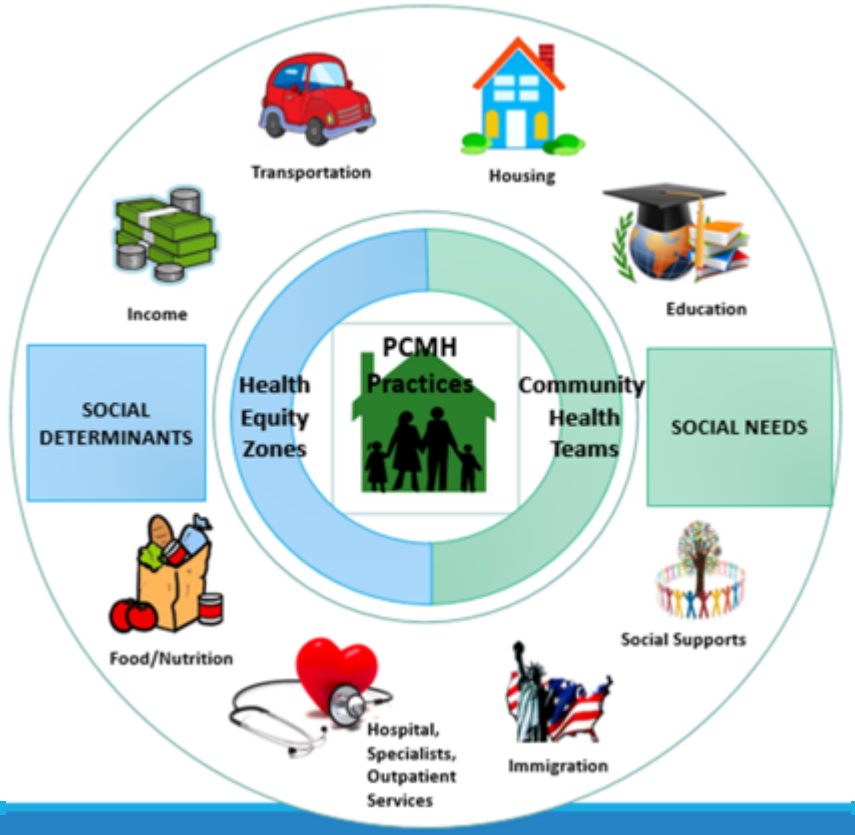
Scope and Staffing: Community Health Teams

Patients Served - Approximately 3,000 patients annually (300-500 per team)

Core Staffing **-** Community Health Workers & BH Clinicians

Partner Agencies – Family Service of Rhode Island, South County Health, Thundermist, EBCAP, and Blackstone Valley

This program is payer-blind - No specific type of insurance is required to participate



Why Stand up this Pilot?

- We had a partner at FSRI already operating both a CHT and a FC program with leadership ready to pilot a new approach to serve families, especially families impacted by OUD/SUD.
- We saw gaps in services and lack of coordination, families without adequate services ***and*** families with too many disparate providers.
- Our partners at Medicaid, BHDDH and EOHHS encouraged and supported this effort.

Our experience so far has far exceeded our expectations
(with this pilot and work across all our CHTs)

Why Stand Up this Pilot?

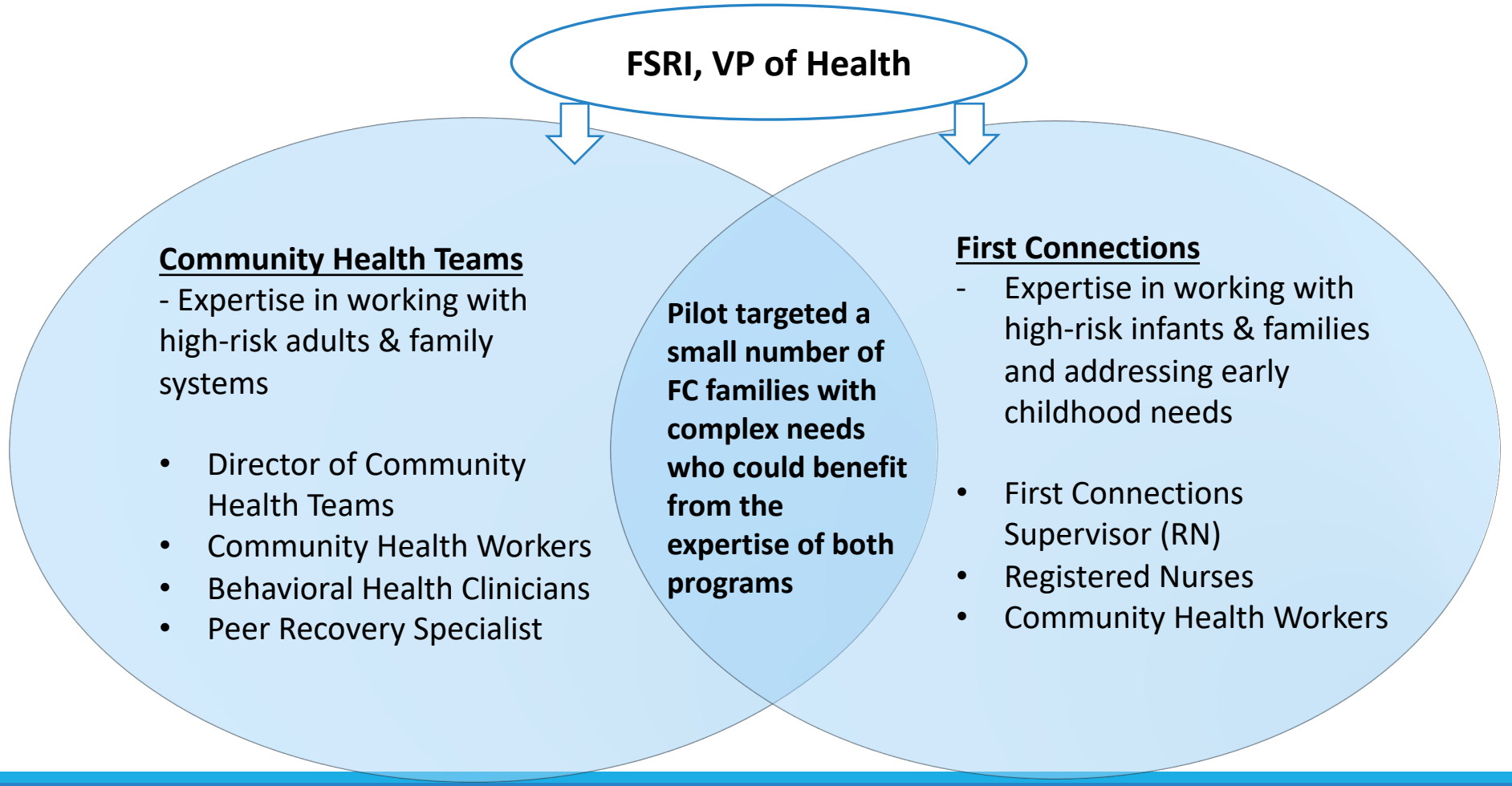
- **First Connections and the long-term evidence-based programs receive referrals for families that have complex family needs.**
  - **Housing and food insecurity**
  - **Behavioral health, maternal depression**
  - **Substance use disorder**
  - **Complex family dynamics**
  - **Historical trauma/distrust of government systems**
- **It takes a team to support families long term, beyond the scope of First Connections.**
- **Responsibility of multiple systems to support families.**

FSRI Multidisciplinary Team (MDT) Pilot

"The strong relationship that the Community Health Team and First Connections staff have developed has been the key to the success of the clients involved in this pilot - working together with the combined goal of improving the health and well-being of both mother and child has been invaluable."

- FSRI staff member, MDT Pilot

MDT Pilot: The FSRI "Family Care Team"



The FSRI “Family Care Team”

FSRI’s First Connections (FC) and Community Health Team (CHT) integrated to become part of a larger “Family Care Team” to improve quality and alignment by having:

- Quarterly meetings with CTC-RI and RIDOH
- Internal Team meetings to share resources, progress, and problem-solve barriers
- Team meetings via ZOOM, facilitated by CTC-RI, to review cases, family needs, progress towards goals, and coordination between external providers.

Services for Enrolled Families

- **Initial Goal:** To serve a small number of families identified by First Connections, affected by Substance Use Disorder and with complex medical, behavioral, and/or social needs.

- **Going forward:** Expand the criteria for who can be served.

- **The Family Care Team focuses on:**
  - Care coordination (with a wide variety of outside providers/agencies)
  - Identification of barriers
  - Providing families with the tools and linkages
  - Joint visits (with FC & CHT staff in the community or virtually)

Small Pilot – Significant Benefit for Families

Benefits include:

- Overall patient/family care
- Expedited referral process
- Decreased gaps in care
- Service coordination
- Care planning
- Streamlined service pathways
- No duplication in services
- Decreased staff burnout through collegial support
- Other programs adopting the multi-disciplinary approach (regular huddles)

Family Care Team Case study

Referred from: Debra Quinton- First Connections

Brief Client Description:

- Patient referred by FC nurse due to multiple concerns and risk factors
- Patient is a female in her late twenties with an infant son
- Patient lives with parents

Risk Drivers Identified:

- History of Substance Use Disorder, currently on methadone
- Uncontrolled chronic infectious disease
- Poor follow-through with primary care
- Lack of employment; Educational/Vocational needs
- No driver's license
- DCYF involvement
- Recently transitioned to home from residential placement
- Family conflict and poor natural supports

Interventions:

- Patient was referred to the CHT **Behavioral Health clinician** for counseling services and to the CHT Certified **Peer Recovery Specialist** (CPRS) who connected her to meetings (online/in-person)
- Assisted patient to **reinstate her license**; helped complete application and provided transportation to DMV.
- CCHW assisted patient in **completing resume and applying for jobs**
- CCHW assisted patient in **completing housing applications**

Family Goals:

- Finishing Medical Assistant schooling
- Secure employment
- Behavioral health counseling
- Peer Recovery services
- Family Therapy sessions
- License reinstatement for transportation

Care Team:

- Community Health Worker (CCHW)
- Behavioral Health Clinician (LMHC)
- Certified Peer Recovery Specialist (CPRS)

Other Partners/Services:

- Residential treatment center
- DCYF—Now closed
- Opioid Treatment Program—for medication assisted treatment and psychiatric care
- Early Intervention
- Healthy Families America
- Recovery Center

Outcomes:

- Actively attending online recovery meetings/ maintaining sobriety
- Baby is stable, attending all peds appointments, and mother is connected to recommended community providers
- Reporting a decrease in anxiety and improvement in sleep for parent
- Stable housing and relationship with family
- Chronic medical conditions are in control
- Patient has an active license, has been attending all appointments for child and herself
- Actively seeking employment
- DCYF has closed services
- Actively engages in an Early Intervention program.

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Future Vision

We want to be able to serve more RI families using this model:

- Payer blind, public/private partnership with sustainable funding
- Use a team approach - a “Family Care Team” -- to effectively provide, support and coordinate care
- Open access for families who need this level of support, without funding-driven discharge dates
- Retain/support staff by reducing staff burnout - more important now than ever before

Our Questions for Today’s Discussion:

Where does this approach to supporting children and families fit into your vision for how our state supports families with complex needs?

Do you see some next steps or potential involvement by your agency to help advance the potential of this team approach to how we support families?

Appendix Slides

SUMMARY: Clinically & Statistically Significant Client Changes after 4.7 months of CHT Care

SOURCE: Redding C.A. (2019, August) SIM Community Health Team Final Evaluation Report. Prepared by University of Rhode Island State Evaluation Team. Rhode Island State Innovation Model Grant #1G1CMS331405.

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

EVIDENCE OF COST SAVINGS

Using cost and utilization data from 2014-2018, a Brown University study examined the South County CHT against a matched comparison group:

$1563

Quarterly difference in total cost care – CHT group vs. comparison group

$6252

Annual difference

$1625

Average annual cost per CHT client

$2.85 Annual ROI

Using the cost savings shown in the evaluation, we can estimate an annual return on investment of **$2.85 for every $1 spent**

*Galárraga, Li, Thapa (2020, May) *Evaluating the Impact of South County and Thundermist Community Health Teams Evaluation Report.* Prepared by Brown University.

Annual savings over comparison group:
$6252

Minus the annual cost of CHT services:
$1625 =

Annual savings of per client
$4627

CHTs Seek to Address Health Disparities

	CHT Clients Served n=519 (7/1/2019 – 5/6/2020)	**Rhode Island** Estimated Population: 1,059,361
Age	**M=57 years (SD: 18)**	**M=40 years**
Non-English Speaker	**24.5%**	**21.7%**
White, Non-Hispanic	**42.3%**	**72.0%**
Hispanic/ LatinX	**37.5%**	**15.9%**
Black/African American, Non-Hispanic	**8.2%**	**8.4%**
Other	**12%**	**4.7%**

When to Partner with a Community Health Team (CHT)

If you are working with a family where the parent has some/many of the following risks identified, and these risks are impacting your ability to meet the objectives set out in the care plan you have developed with the family:

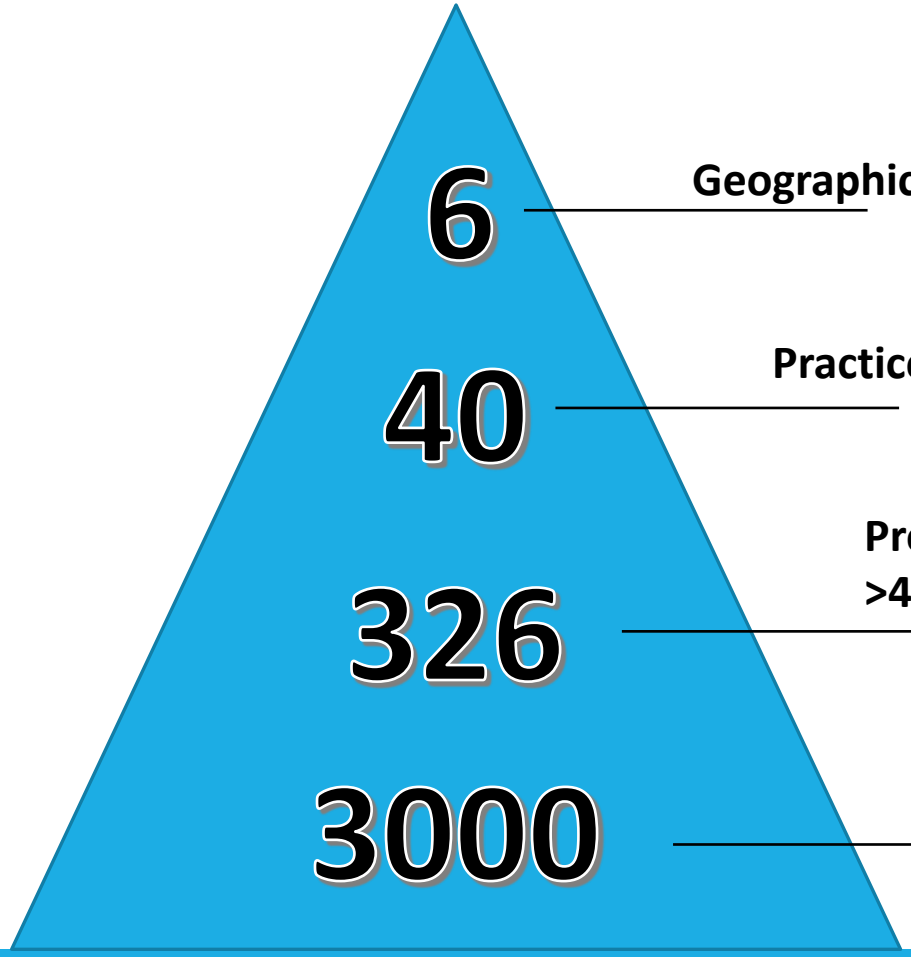
- Substance Use Disorder
- Poorly controlled high-risk chronic diseases (i.e. diabetes, chronic pain, COPD)
- Frequent hospitalizations or emergency room visits
- SDOH risk factors (undocumented legal status, food insecurity, risk of homelessness, etc..)
- Functional impairments (difficulty getting to appts, inability to follow medication regimen, fall risk, impaired ambulation)
- Mental health concerns

Then, this might be a great opportunity to partner with the Community Health Team (CHT) and work in coordination to facilitate the best possible outcomes for the family.

CHT Contacts

Region	CHT Agency	Contact Information
Pawtucket/Central Falls	Blackstone Valley Community Health Center	Scott Hewitt, MA CHT Manager P: 401-602-4046 shewitt@bvchc.org
East Bay	East Bay Community Action Program	Carla Wahnon, MHS Manager of Integrated Health Care P: 401-437-1000 ext. 107 cwahnon@EBCAP.org
Greater Providence	Family Service of Rhode Island	Vanessa Cubellis Director of Community Health Teams P: 401-864-8977 cubellisva@familyserviceri.org
Washington County, Kent County	South County Health	Cassandra Stukus, LICSW Team Lead P: 401-788-8526 cstukus@southcountyhealth.org
Woonsocket, W. Warwick	Thundermist Health Center	Gloria Rose, RN Director of Community Care Management P: 401-767-4100 x-2384 GloriaR@thundermisthealth.org

CHT Relationships and Reach



Geographically based CHTs

Practices with referring relationships to CHTs

Providers with referring relationships to CHTs - >40% of adult providers in RI

Adult patients directly served by CTC-RI CHTs in FY 19

CTC-RI is the State's Multi-payer Health System Transformation Initiative

CTC is co-convened by EOHHS and OHIC per enabling legislation – and an asset that can be leveraged by Medicaid

Relationships:

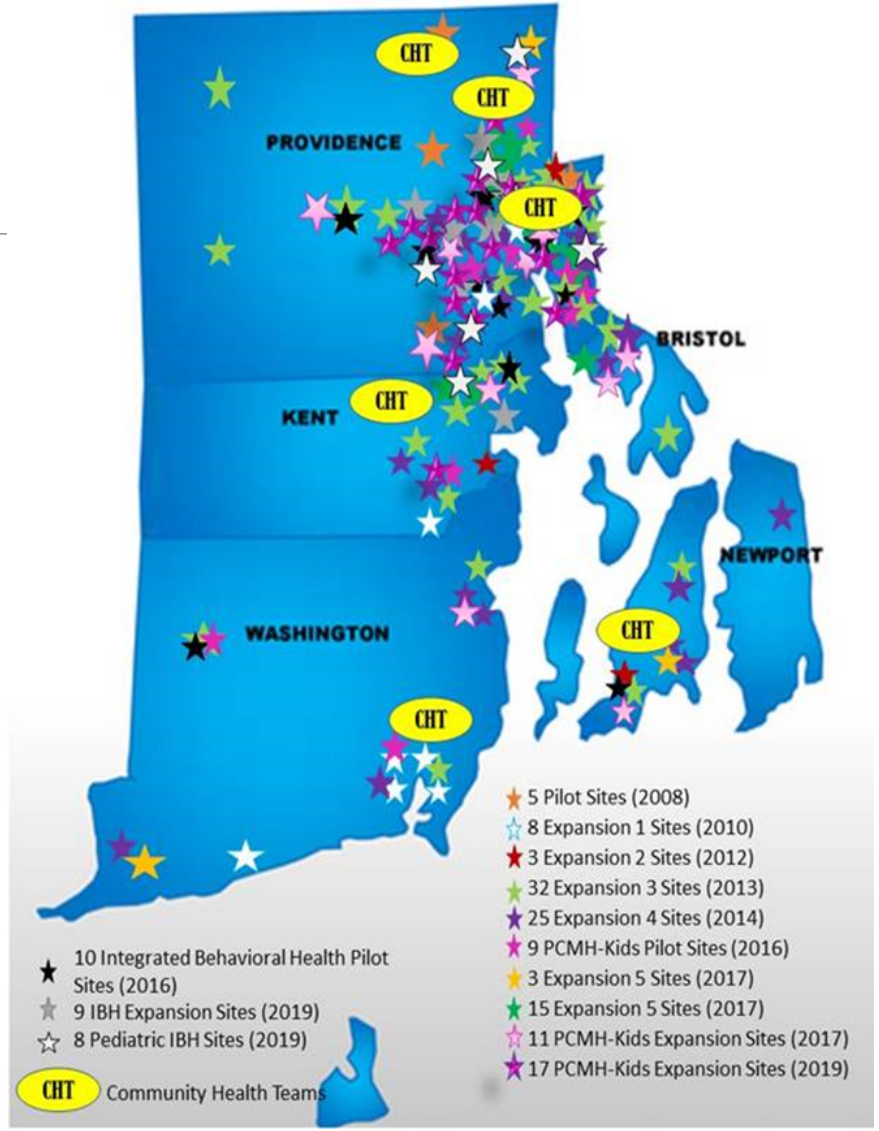
- CTC-RI brings together key stakeholders – 23 member Board of Directors and multiple public/private committees
- CTC has working relationships with all FQHCs and AEs

Scope of reach:

- Approximately 700,000 Rhode Islanders receive their care in a patient-centered medical home
- 85% of Medicaid children served by PCMH Kids practices

Learning & Data:

- CTC convenes learning collaboratives to identify challenges and share best practices
- CTC has ability to collect and report data on practice performance including customized reporting from APCD
- CTC is an effective contract manager for multi-payer/funder initiatives



MDT Pilot Staff Survey Comments

Specific Client Outcomes:

- "The MDT pilot has allowed for the multiple needs of a family to be met at the same time. For example, while a parent is learning how to foster the healthy development of their child, they are also getting assistance in securing stable housing and have someone helping them in their road to sobriety."

- "Long-term sobriety; crossing of specializations that allow long-term opportunities for clients and education around medical lens for newborns and parents and their struggles."

MDT Pilot Staff Survey Comments

Overall Value of the Pilot:

- “The strong relationship that the Community Health Team and First Connections staff have developed has been the key to the success of the clients involved in this pilot - working together with the combined goal of improving the health and well-being of both mother and child has been invaluable.”
- “The most valuable service has been being able to simultaneously meet the needs of the caretaker as a parent, and as a whole person”

Challenges:

- “The biggest challenge has been to engage outside partners in the team meetings, for a variety of reasons.