Data, Evaluation and Best Practices

Date: 10/13/20

Time: 1-2pm

Location: Meeting URL: https://healthmanagement.zoom.us/j/91271393398?pwd=ZlhQTC9qYnB3aklhU3NWZWFVTjFJQT09

Meeting ID: 912 7139 3398

Passcode: 894728

Facilitator: CAITLIN THOMAS-HENKEL AND DIANA RODIN

Attendees:

Kristin Dwyer, Chris Kelly, Laura Rapp, Gloria James, MJ Scales, Terri Cook-Fausano, Thowana Weeks, Patches Hill
HMA: Diana Rodin, Caitlin Thomas-Henkel

Agenda

- **Welcome and Call to Order**
- **Literature Review Discussion**

Literature review matrix

Diana Rodin provided an overview of the literature review including the states that we examined.

Students with BH Needs

- Offering MH services in schools;
- Where do recovery high schools fit within the context of School Based Health Centers? Not clear about where these are at in terms of DE. Recovery high schools tend to be isolated into a separate group. May not fit necessarily/ holistic way to approach students in recovery. With high rates of addiction and overdoses.

- Operations group- the community school model comes into play as it covers all aspects of the child's life. May be experiencing sexual abuse, unmet social needs- to provide the right connections and support. A better model for the holistic approach. Having someone ho is a trained medical health professional. Rutledge and Community have the community schools model in place. They also employ CHWs Children and Families First; addressing these needs. Does this model include drug and alcohol?
- Christiana is doing all of the steps and pieces for SBIRT. They have not been trained in SBIRT. All students receive a risk assessment and the CRAFTT assessment. Talk about options. Aquila provides services for a specific. 32 out of 39 centers provide some level of SUD services.
- How many screenings do SBWC offer? Are these screenings interwoven with BH screenings?
- Christiana has a risk assessment/ then follow up with a more detailed assessment. The data shows a mix of data/screenings. Columbia and Beck screenings used for assessment.
- Need: understand what screenings are happening and then what happens once kids screen positive for services. Uma has this information.
- DTRN Tracking referrals and what happens for both? The data for screenings and number of students seen is being collected. Does not currently capture other services outside of SUD and MH services. Laura Rapp's team is involved in the evaluation.
- Laura will follow up regarding data on diversion and efforts to identify MH issues and address a broad range of issues. Kathy thinks DE is missing sufficient outpatient tx for adolescents and bolstering the system for kids. Each school based medical sponsor operates their BH services differently. Christiana offers weekly therapy. There are barriers such as transportation to seek MH tx. There are external referrals that happen more in other parts of DE. Christiana is providing psychiatric child and adolescent telehealth services to fill gaps in care. If medical health sponsors can directly provide direct services or partner with other orgs. to provide BH care.
- How can we maximize these resources in DE to ensure children have access to MH care to minimize referrals? Maximize role of tele-behavioral health services, partner with other orgs.
- MJ Scales Project Aware- through increased usage of the Multi Tiered System of Support to triage kids to conduct assessments; and to identify providers with that specialization. It is in 3 districts.
- There are differences in how schools operate and adopt different standards based on how it is integrated across schools.
- Ensure closer integration and alignment between with the over school community and the MTSS and PBIS.
- Maximize resources for tele behavioral health services.
- What about standardizing screening for Behavioral health and/or SUD services? To adopt a standardized tool for screening SUD and BH. It's important to understand what's being asked.
- Kathy asked about a different tool beyond the Raaps tool. Is this something that we should use in addition? By contract the 32 schools use the wrap risk assessment; then do we want to identify a uniform tool to SUD. If we require the BDI BII then we would need to provide additional resources or funding. PHQ-9: for depression. Propose that we encourage screening tools.
- Gloria: when we had a decentralized data base then we looked at costs.
- Could tele-behavioral health be utilized.
- Christiana has 18 SBWCs that operate in DE. One medical sponsor has three SBWCs in Suffolk County. One medical sponsor may have the clinical social workers with the students; then they f/u with the student.

Barriers to reproductive healthcare:

- One barrier is the elimination of EOBs. Long standing issue; Gloria is in conversation about this. How to deal with EOBs. This is a hue barrier for treatment. Coordinated with the policy (pg. 14) about EOBs and insurers. SBWC are based on need in other states. The problem as to do with third party self insured parties. MCOs have noted that they will not suppress the EOBs. More of an insurance issue. Linkage to the finance workgroup/ that these services are not accessible to support the student that is seeking care.
- Opportunities: not all centers offer LARCs because the school boards must approve the services. They can offer reproductive health but not LARC. Linkage to the policy workgroup and making changes.
- Medical sponsors have to seek permission from the school boards to offer services to the district. Have to go to each school board for permission. Reproductive health wasn't activated until 2012. Even if the school board approves it; parents can opt out of reproductive health.
- The majority of school based wellness centers. A 12 year old cannot access reproductive health care without consent from the parents. DE Code for 12 year olds.

Trauma informed services

- California School-Based Health Alliance Field Guide

- **Adjournment & Next Steps**