

Pediatric Mental Healthcare Access Grant Advisory Committee

Meeting Summary

April 19, 2019

Attendees attended via in person, phone, and Zoom connection. Attendance lists available by request.

Welcome, Introductions and Housekeeping

Pick a name for the Pediatric Mental Healthcare Access Program of Nebraska

1. Mental Health Access Project for Youth (M-HAPY)
2. Healthcare Access Project for Youth (HAPY)
3. Behavioral Health Access Project for Youth (B-HAPY): 5 votes
4. Child Healthcare Access Project (CHAP): 4 votes
5. Healthy Minds. Healthy Kids. 24 votes
6. Healthy Minds Nebraska: 4 votes
7. Mental Health Connect: 2 votes

The winning name is Healthy Minds. Healthy Kids.

Family case study: what is happening in our family, in our community, why is that, what can be improved? How are parents accessing mental health care for their children?

Anna Whaley, a parent representative, shared her story about how she has struggled to access behavioral and mental health care for her kids as well as how the school communicated to her about potential behavioral issues.

Discussion:

- Having telehealth at late hours would be very helpful so kids won't miss school and parents won't miss work.
- Even with caring parents, children sometimes won't share their feelings at home, especially teens. In Anna's story, her teen didn't want to "disappoint" her parents. It means a lot if they can have a trusting adult at school to come to for help.
- School personnel continue to support this family through watchful, caring relationships and helping to make transitions smooth.
- What could have been different?
 - o "Perfect response chain": school personnel recognized a safety issue, rapidly built good report with the teen, informed parents, and parents responded right away.
 - o It could be helpful, amid chaos, that someone can step in and help parents learn how the system runs, and sort out insurance loopholes and available resources.
 - o Parents can keep their private insurance, and Medicaid comes in as the second tier.

Other situations and resources discussed:

- Lifespan Respite website gives an impression that people need to be eligible for the subsidy to join the respite program, and does not tell parents that they can negotiate the hourly rate with providers.
- Generally, Respite providers only have overall training, and parents of children with disabilities can struggle finding appropriate care for a break. Often, when parents explain details of the kids with DD, providers back out.

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- It is not easy to search through the Nebraska resources referral system for childcare specializing in children with DD and/or behavioral issues.
- Receiving resources from state child protective services means that parents open themselves up to investigation.
- For families that are listed at the bottom of the eligibility list and are having crisis, it takes time to move them to the top of the list to intervene into the situation at hand.
- Resources for a family in crisis: Community Response, NE Family Helpline, Professional Partner Program of behavioral health, local crisis response, regional behavioral health and law enforcements have their own local protocol to reach out and get services. Youth Mobile Crisis Response service can be reached via NE Family Helpline.
- Police baseline reactions at family crisis points do not seem to be enough some times. They need to actually come in to look at in-home details of the situation and talk to the parents.
- Developmental delays go unrecognized in young babies turn into serious and sudden meltdown in big kids.

Report out:

- Clinical Demonstration Project: Holly Roberts reported on the progress of the project. UNMC developed a questionnaire that was going out to 43 health clinics in mid-April. It will be expanded to statewide clinics later. The first step is to utilize the existing MMI network of 43 integrated behavioral health in a primary care setting clinics across Nebraska. This survey is an activity addressing Goal 1 of “*Enhance early screening of behavioral health disorders in childhood and adolescence.*” The survey was designed to check upon regarding current screening practices for behavioral health needs of children ages 6 months to 16+ years. Data collected will inform us where we need to target, additional screening practices or more training etc.
- Technical Workgroup 1: Jenni Auman provided a brief report. The group was formed to look at currently available screening tools and conduct an analysis on: *what is being used, what is easy to use, how to get them to physicians, how to train physicians, and what to do if the screen is positive.* The plan here is to create a simple menu of widely accepted screening tools in early childhood mental health, depressive disorder and substance abuse in youth, domestic violence, trauma exposure and other main struggles. The group also honors and taps into related work already completed by other initiatives, especially the work of a discontinued program of DHHS called “Together for Kids and Families” around a universal screening tool. The Technical Workgroup will refine the menu and submit to the group.
- Evaluation project: Kathy Karsting indicated that pieces of the performance measurement and evaluations of this grant finally came to shape. This national project, with its many complex layers, is hinged with another national project on maternal mental health. There is one national evaluation project for them both.
- To summarize, this grant is subject to one national evaluation project, one performance measurement layer adopted by HRSA (funding source), one layer of measures from the Maternal Child Health Bureau, one layer called Congressional Justification Measures, and regular and routine report to Congress about the project and progress.

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Data is drawn from the clinical demonstration project and impacts achieved statewide. Work products are developed for input from this group such as the screening menu. There are other placeholders such as family inclusion (how the healthcare system changes to make it better for families), what CLAS would look like, equity issues around who is not being screened, who is not referred, who is referred and not getting the service and support they need.

Some details of this grant:

- Population served is aged 1 through 24.
- One of performance measures is number and percentage of youth seen in primary care who are screen for major depression disorder.
- It is expected to relay and convey the data story of the project aligning with the behavioral health System of Care, so tracking the zipcodes is intentional to locate how the access system works.
- Part of the focus around screening is what is happening in community settings.

Evaluation partners will come to present to the committee more about this project.

What's next?

- *Potential Technical Workgroups*: Jenni will send out emails surveying about potential technical workgroups that could enable this committee make a difference:
 - Integrating CLAS standards and making recommendations for the clinical project and for the screening menu.
 - How do we ensure family inclusion at all levels? What does that look like in our systems-integration?

Next meeting: Friday, July 19, 2019 9:00a – 11:00a