**Goal of the Grant:** to improve behavioral health outcomes for children and youth (birth through age 21) who meet criteria for SED and their families and who have child welfare involvement. For this project, child welfare-involved families are those for whom a child abuse and/or neglect investigation results in a substantiation or services-needed finding.

**Purpose of the GMIT:** interagency team responsible for management of the grant, oversight of state and local implementation activities, and ongoing communication with the system of care governing bodies.

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| **Attendees** | | |
| Dee Dee Ward | Kelli Root | Randa Bush |
| Kelly Dorman | Christi Porter | Michelle Niehaus |
| Kelly Bradshaw | Erix Delgado | Barb Greene |
| Tammi Taylor | Katy Mullins | Sherri Staley |
| Joy Varney | Mary Carpenter | Michelle Niehaus |
| Chris Cordell | Katie Kirkland | Michelle Sawyers |
| Christa Bell | Jessica Ware | Leslie Hughes |
| Clarissa Allen | Ayanna Coates-Hendricks | Jennifer Warren |
| Jeremiah Pope | Tracy Desimone | Maxine Reid |
| Beth Jordan |  | Lizzie Minton |

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| 1. **Data Discussion** | | |
| Screeners vs. CANS- Jeremy Pope, UK HDI  Jeremy presented on the “SOC Treatment Pipeline” This included numbers of the following steps in the Pipeline: Substantiation or FINSA, Screening, Referral to Assessment, Assessment, Referral to Treatment, Treatment, and NOMs. He first presented numbers from the model created at the onset of the grant. Then, he presented the monthly averages for October 2021-Janaury 2022. He showed the numbers at each step and the Retention Percentages (step to step).  Comparing current data to the model showed that:   * We are missing data on substantiation/FINSA * We are screening four times the amount of people expected. * However, the percentage referred to assessment is lower. * And the percentage assessed is lower. * The model expected an 18% Screening to NOMs rate; currently, it is 2.5 percent.   Here are some notes from the discussion:  Need to add Substantiation/FINSA numbers:   * Chris Cordell explained that if you want to look at a specific number, would need to do a special data pull. * The cohorts are two service regions combined, so those intake statistics are available. * HDI can work with Chris Cordell to get a better number for SGMIT.   GMIT member asked if perhaps the tool is not sensitive enough:   * Lizzie- 65% OOH population referred to assessment (anticipated 80-90%) * Makes sense that not as many in-home are screening in. * Lizzie has clinical cutoffs for the tools if that would be useful. * We thought we made the tool [DCBS screener] sensitive enough * Lizzie said they can review cases and look at the fidelity of the tool * Beth J- we are talking about different populations; it could be the symptoms/needs of the family [rather than the child] are greater than the behavioral/health needs of the child. * We didn’t overestimate need; we are just not looking at the full picture in our model   Mary C- DCBS expansion of prevention services could be a factor:   * agree with looking at the screener in combination with FPP services * Consider how screeners/CANS are discussed with the family * We need to know if the workers are making this referral [FPP services] maybe they are not also referring to this [CANS referral] as well. * Posing this question at regional GMITs/ask DCBS to reach out to their front line * Katy M- Send questions ahead of meeting time [DCBS supervisors will need time to discuss and prepare information to share at RGMITs] * Need to know from front line staff what this process looks like for families * Making multiple referrals? Those receiving intensive services are they also referred for a CANS * Dee Dee will reach out Cohort 1 &2   Michelle S- AOC utilizes Inter-rater review (principles of effective intervention); found that this was helpful for creating fidelity in screening.  Lizzie- we did 100 case reviews for Project SPAFE SPACE   * reviewing information in TWIST/ look at service request and several data points * happy to share the form created [for project SAFE SPACE] to identify items missed * Barb- fidelity slips occur in many projects, hesitant to assume the screeners aren’t being done with fidelity, rather that perhaps there is miscommunication occurring before, during or after * Randa- The ask is on the families to do so much documentation, could be lost in the process as this causes frustration on a family to answer questions multiple times. Families can refuse the NOMs – not very therapeutic to ask all those questions. * Beth J- suggested we look to how clinicians doing the CANS   + Should be gathering information from all sources rather than asking many repeated questions to a family   Katy Mullins asked, how are we coming up with the NOMs target? Jeremy P- 90 per year was put forth in the original model which equals 7.5 NOMs/month; current monthly average (from the last four months) is 4.3 NOMs.  Beth J- We are working on the system as a whole; SAMHSA only records NOMs to capture outcomes.   * Cohort 1- rolled out slowly due to COVID, but we expect to see more in the coming months. * The bottom line is: Are we connecting families to support who are needing and searching for support? * We don’t have a choice in completing the NOMs   Randa- we are reviewing information already to collected to try to eliminate the repeated question, however there are still many questions that have to be answered in the NOMs asked of families   * New Vista is hiring a family peer support to assist   Michelle N- chat question: Barbara, I'm curious if you've noticed a difference in follow through or willingness to seek treatment if a peer vs a worker or clinician refers for the next step?   * Barb- The sooner peer support gets involved, the sooner we can help families through the referral process   GMIT members noted that there are a lot of points of contact before the NOMs is given.  Beth Jordan- we might discuss if we can move the NOMs up in the process.  Barb wanted to know if parents would know what the NOMs was—  Beth J- You would have to ask clinical staff that question.   * NOMs language was shared early in the grant which would be more casual language to help people understand * that might be helpful to review/share again   One member wondered about the alignment of implementation processes with court demands/expectations of families. Dee Dee noted how not all in-home families are in court.  Sherri Staley noted there might be overlapping with other programs such as KTAP   * Discussion about how data overlaps would be helpful among programs that collect data   Leslie Hughes said it would help to see what the terms mean—what data points are referencing.   * Update: The Data & Evaluation page of the SOC FIVE website (<https://socv.hdiuky.net/grant-application-foa-files/?sf_tag=data-evaluation-files/>): contains links to the “SOC FIVE Services Intervention Pathway” and the “SOC FIVE Regional GMIT Data Expectations Tip Sheet.”   Someone asked if the NOMs are only completed by CMHCs. NOMs are to be completed by SOC-funded providers. In addition to CMHCs, this includes BHPs like Uspiritus in Cohort 1 and Boys & Girls Haven in Cohort 2.  There are a lot of referrals going to independent/private providers.  Should we identify additional data we might want to look at?   * CQI specialists will discuss at their meeting * Katie asked if we could look at the systems data available (in terms of the pipeline); Beth said we could discuss further in the Evaluation Subcommittee.   Peer Support- Barb Greene  Average length of service- initiating services:   * 30min- 1-hour [largest group is over an hour]   Started to track different counties [new]   * Largest referral source: DCBS and Cumberland   SOC FIVE families are growing- Thank you to those who are sending those referrals!  Collecting ages of the children in families   * 0-5 population largest in SOC FIVE families   Getting some [referrals] in Salt River Trail  Satisfaction survey responses have started trickling in  Would love to have a conversation around the ‘referral source’   * calling it a ‘partner satisfaction survey’ to capture more people’s opinions of those invested in the family’s engagement in services * Continue to meet with the Evaluation Team * Follow up on Satisfaction survey * What’s the definition of what success?   + looking a creating a focus group to better answer that | | |
| **Action Items** | **Person Responsible** | **Deadline** |
| Evaluation Committee meet to discuss/determine substantiated/FINS numbers to compare screener numbers. | HDI | April 2022 |
| Request SRAs in Cohort 1 present feedback from frontline about screener completion w/ families | Regional Implementation Specialists | April 2022 |
| Discuss points of data with CQI Specialists | Kelly Dorman | April 2022 |
| Create a Focus Group to develop a Partner Satisfaction Survey and define what “Success” looks like. | HDI/Barb Greene | June 2022 |

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| 1. **Regional GMIT Update** | | |
| Cohort 1:  Maxine Reid, Cumberland Region:   * SOC FIVE RIAC funds: being discussed and utilized * partner funding requests have been processed * Doing outreach to FRYSC on Peer support and SOC FIVE services   Kelly Bradshaw, Two Rivers Region:   * SOC FIVE RIAC funds: Barren River RIAC’s goal is to reduce truancy referrals to reduce number of DCBS cases [educational neglect is being filed frequently in the region]. Green River plans to purchase Resource kits to reduce out of home * RVBH: New high fi wrap around coordinator, Chris Bentonwhite is LRC. COVID has impacted their building and working on skeleton crew on rotation * Lifeskills- has received 2 respite referrals * Jessica Humphrey will be facilitating DCBS front line presentations * Uspiritus is working on referrals/outreach   Cohort 2:  Tammi Taylor, Lakes Region:   * Just started GMIT in Nov, so far so good * 2 parent reps on the RGMIT and 1 youth identified has considering joining * RIACs have decided to spend funds on families. * Screeners have started but going slow.   Kelly Dorman, Salt River Trail:   * March will be the roll-out * January RGMIT included an overview of all the regional providers * This month is family/youth engagement; we have a parent rep * Website set up to show resources * Identifying youth seeking substance abuse treatment * Working with CQI on data | | |
| Action Items | Person Responsible | Deadline |
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| 1. **SOC FIVE Subcommittee Updates** | | |
| Respite Tracking Group: very engaged meetings which result in more questions. Orphan Alliance serve families with respite providers  There is room to create a tiered respite program if it could be funded and organized. DMS will be joining meetings. | | |
| Action Items | Person Responsible | Deadline |
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| 1. Agency Updates | | |
| SOC FIVE   * [February 2022 SIAC Meeting](https://us02web.zoom.us/j/89069145980?pwd=dHE1MWs2aTdCRjVGZXVCdTVpQWlGUT09) 02/23/22 from 2-4 [Dee Dee will be providing an SOC FIVE update] * Stephen Kniffley running a pilot racial trauma therapy program, still seeking clinicians across the state to participate   DCBS   * DCBS Prevention group- smaller work group has developed a prevention plan looking at what’s the best way to move forward/implement those plans * How we navigate barriers as they arise   AOC   * implementing respite as an alternative to detention through NECCO partnership | | |
| Action Items | Person Responsible | Deadline |
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**Next Meeting:** March 11, 2022via Zoom: [March S-GMIT Meeting](https://us02web.zoom.us/j/82154195143?pwd=anYrVjlJRXQ4ejgxaDRYeDFCQ0IrUT09)