ILLINOIS DEPARTMENT OF PUBLIC HEALTH
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Meeting Minutes of:
ILLINOIS DEPARTMENT OF PUBLIC HEALTH
Social and Emotional Learning Committee

Monday
May 7, 2018
10:00 a.m. – 2:00 p.m.

IDPH Offices **69 W. Washington** **35th Floor** **Chicago, IL**	**IDNR Building** **One Natural Resources Way Lower Level** **Springfield, IL**

Attendees

Members in Attendance	Members Not in Attendance	Guests
Allison Schuck	Barbara Bayldon	Gene Griffin
Amy Starin	Monica Spence	Susan Scherer
Maryam Brotine	Cynthia Tate	Heather Alderman
Brianne Daubenspeck	Jeff Aranowski	Amy Zimmerman
Lisa DeVivo	Bambi Bethel-Leitschuh	Jessica Hoffen
Brenda Huber	Lisa Betz	Allison Lowe-Fotos
Jamilah Jor'dan	Shawn Cole	Lydia Maldonado
Sandra Lawinger	Juliana Harms	Jessica Adamson
Shannon Lightner	Kati Hinshaw	Jennie Pinkwater
Andrea Palmer	Judith Howard	Marie Irwin
Tanya Dworkin	Jennifer Jaworski	John Stallworth
Jean Becker	Molly Lamb	Chelsea Dade
Conny Moody	Brandy Lane	Kristen Woytowicz
Becky Doran	Virginia Reising	Monica Wright
Mary Dobbins	Andria Goss	Stephanie Jones
		Annette Charles (Facilitator)
		Ellen Byrne (Facilitator)

Motions

Motion to approve minutes from March 23, 2018 meeting. Passed unanimously.

Introductions

Facilitator Annette Charles called the meeting to order at approximately 10:00 a.m.

Minutes

Minutes from the March 23, 2018 meeting were reviewed and approved.

Agenda Items

1. **Welcome and Level Setting (IDPH)**
    a. Shannon Lightner provided level setting and background on the first meeting; With regard to the requirement of consistency with ISBE standards, it's the rules that need to be consistent with ISBE standards, not the selected tool(s); Reminder that legislation doesn't require schools to offer screenings, students can't be kept out of schools if they're not screened; Reminder that the legislation addresses screenings, not assessments
    b. Tanya Dworkin reviewed the rules process and timeline; advised that DPH cannot implement the rules until they're effective; anticipated timeline is 12-18 months from when DPH starts drafting the rules

2. **Facilitated Discussion (Facilitators and Committee Members)**
    a. Stephanie Jones from ISBE Legal on the Intersection of Related Laws – How does this Act relate to other laws and consent decrees that require privacy and/or service to children/youth screened?
        i. Discussion of what constitutes a school record and explained the difference between a temporary record (5-year retention) and a permanent record (60-year retention)
        ii. Rules should be clear about what a school needs to maintain with regard to the screening/documentation of whether the screening was done, and this is done by indicating whether the school must or cannot keep the documentation
        iii. Child Find – provision of IDEA that creates affirmative obligation to identify students who may have disabilities and either (1) seek consent from parent to evaluate; or (2) monitor student for a while.
        iv. Not aware of any consent decrees implicated with regard to ISBE
        v. The selected tool(s) should be as culturally responsive as possible
    b. Stakeholder Committee - Establishing parameters within the regulations to enable widespread implementation
        i. Review of the 9 areas of general agreement; everyone agreed it accurately represented the discussion from the first meeting
            1. Discussion about what constitutes privacy, especially in relation to where the screeners are filled out vs. where the results are given
            2. Reminder of preference that this be done in a medical home
            3. Reminder that there are HIPAA implications regardless of where the screens are done
        ii. Should the "qualified person" who "administers" the screening be a medical professional or mental health provider, or may they simply be training in the use of the tool(s)?
            1. There's a difference between administering (giving the screen) and implementing (interpretation of the screen)
            2. Discussion of who should be responsible for interpreting the results – mental health professionals, medical professionals, professionals trained on the tool, nurses, nurse practitioners, etc.; Should be flexible. No consensus reached.
        iii. Must the regulations address the reality that screenings may be conducted by others and shared with the individual who is completing the health examination form? Should they accept and record in the form?
            1. Most providers won't do this themselves. Suggestion that someone teams with the medical provider and takes ownership, and also designate where the information came from because sometimes families will fill out the screeners.
            2. Reminder that if this is done in the school, it becomes part of the student's record.
        iv. In what important ways do these regulations intersect with related laws, consent decrees around privacy and required service to children and youth with identified developmental and/or socio-emotional concerns? To what extent do/should the other laws affect the writing of these regulations?
            1. Mental health and other confidentiality codes have implications; recommendation that rules require medical professionals to comply with applicable confidentiality requirements
            2. Note whether the record is temporary or permanent, and consider whether it's a record that should follow the student for ongoing diagnostic/tracking purposes

3. Consider informed consent requirements, and properly educate parents on informed consent and SEL/Developmental screens
4. It should never be necessary for the school to do the screenings. Some might want to, but lack capacity to do so
5. There are no consequences for not having SEL screens done

c. Stakeholder Committee - Identifying age-appropriate, validated screening tools
   i. Review of the 12 areas of general agreement; everyone agreed it accurately represented the discussion from the first meeting
      1. Reminder of the language gap that could have a big impact on implementation – most tools are only in English and/or Spanish, though the SDQ has a lot of language options
      2. To the extent possible, tools should be free, easy to use, and practicable
      3. Being trauma informed is important, but we don't want to re-traumatize students as they're being screened
      4. What's the goal if we collect information on ACES? What's the follow up? How do we support children and families after reviewing that information?
   ii. What is the right timing/process for IDPH to use to create/update the list of approved screening tools (frequency, stakeholder guidance, etc.)?
      1. The list should be reviewed at least annually, but preferably every 6 months
      2. Consideration should be given to what it means to be valid and reliable
      3. Ideally lay out criteria in rules, give guidance to schools, provide list of validated tools that meet criteria, create a method for new tools to be submitted, reviewed, and added. But who will review the proposed tools? Look to how HFS does this.
   iii. Must the screening tools on the IDPH list be reimbursable by Medicaid and/or other insurance carriers?
      1. Consider having some tools that are reimbursable and others that aren't so parents have options
      2. Not known whether any groups are currently working on creating culturally competent tools
      3. Early Learning Council currently taking on the idea of learning equity
   iv. How do we communicate the minimum standards for use of validated tools, but also (i) leave room for the creation of tools for ages that do not currently have them (developmental tools for youth); and (ii) allow for more elaborate assessment/evaluation, if warranted?
      1. There are no developmental screens for 9th graders
      2. Sometimes with cognitively impaired students, screeners for younger students are used
      3. Most tools have recommendations for who is qualified to interpret, so be careful with rules language around who can interpret.
      4. The Lead Poisoning Prevention Act (410 ILCS 45): "health care provider who sees or treats children 6 years of age or younger."

d. Implementation Perspectives – Presentations by Amy Starin and Brenda Huber
   i. Grantor ICHF
      1. Discussion of what ICHF does, and the importance of connecting kids to care after screening is done
      2. Ideally, there would be a child mental health professional in the settings where screenings will be done
      3. Grantees feel it's more important to ask questions about SEL/Development than to prescribe specific instruments; This will help reduce stigma in the community
      4. Important to support community diversity and cultures
      5. Important to identify workflow
      6. Important to get stakeholder buy-in, which takes a couple of years (school systems and medical systems)
   ii. Grantee Livingston County
      1. Created four-tier public health models from age 0-18
      2. Greater percentage of participation with passive consent
      3. Think about getting the screening in the hands of people who have front-line contact with the children, then give the results to someone with the training to interpret/act

4. Current culture change is towards primary care asking families about SEL and mental health issues
5. Screeners are not intended to diagnose, so positive screens need to have next steps

e. Articulating expected implementation challenges
   i. Review of the 12 areas of general agreement; everyone agreed it accurately represented the discussion from the first meeting
      1. Need to think about whether the screen will be part of the student's record
      2. Need to think about whether we would require informed consent; Keep in mind that some school districts do universal screening without requiring informed consent, and we need to ensure that if the SEL rules require informed consent, we don't impact the universal screens
      3. If schools are doing the screens, we probably want express consent rather than passive consent
      4. If one child receives unique services, active consent is required; if all children are getting the same service, passive consent/opt out is okay
   ii. Health Exam Form: How do we include the option to refuse screening without discouraging providers, parents, and youth from completing important screenings?
      1. Discussion about giving the option at the time of screening without making it part of the form itself
      2. Discussion about a yes/no/declined option on the form re: whether the screen was offered and done; do we want to indicate why, if the screen is not done or declined?
      3. No resolution on this issue yet
   iii. Given that implementation is beyond the scope of these regulations, which are the right statewide bodies to take on the development of guidance/training for providers and community-wide efforts to build awareness and access to services?
      1. Suggestion that ILCAAP, ILCHF, and IL Children's Mental Health Partnership might take leading roles
      2. Need to ensure a cross-sector approach to ensure everyone is using the same definitions, comes to the same table, and reaches consensus
      3. Talk to the advocates to get help in working on the next iteration of the legislation so it can be better implemented and embedded as part of the Illinois system

3. Public Comment

a. Amy Zimmerman – Legal Council for Health Justice
   i. Was an advocate who helped draft the bill
   ii. States that sponsors chose the child health exam form as the vehicle to promote SEL/D screens with the goal of destigmatizing screenings
   iii. Believes that SEL screenings ARE required, so it's only optional for a parent
   iv. Believes medical providers should do the screenings
   v. Believes legislation is clear that screens are age-appropriate, so don't recommend one if it's not age-appropriate
   vi. Wants to see a place for annual updates to the list of tools
   vii. Believes the child health exam form allows for release of information and sharing of whatever is on the form, but results may require a separate release; Believes it's important that consent needed by a school is done in a way that doesn't dissuade the screens from taking place
b. Allison Lowe-Fotos – Ounce of Prevention Fund
   i. Early Childhood: intent of law is to decrease stigma around SEL/D screens; reinforce that screening is not a diagnosis
   ii. Urges us not to be overly proscriptive or prohibitive; many early childhood screens are meant for anyone to be able to interpret
   iii. Regarding DCFS, we're not talking about just Kids in Care. Licensed daycare programs, including Headstart, use child health exam forms, so what we do will have an impact there and affect the 0-3 space
c. Jennie Pinkwater – IL Chapter of the American Academy of Pediatrics

i. Urges us not to be overly proscriptive, particularly in relation to primary care settings. Suggests that we consider splitting the discussion between screens being done at a doctor's office and screens being done at a school
ii. Notes that the child health exam form is signed by the primary care physician
iii. Points out that physicians don't always know what's on a child health exam form, and they do the same exam they'd do for every student of a particular age and fill out the form at the end of a visit. In other words, the form doesn't drive the visit.
iv. Notes that the IL Academy of Family Physicians is aware of these SEL meetings and the rules changes that will result

d. Jessica Adamson – Aperture Education
i. Vendor/publisher of the Devereux student strengths assessment (DESSA)
ii. Lessons from the last 20 years: (1) language matters, and the questions we ask provide a lens for thinking about the screened child, so we should use strength-based assessments; and (2) tools can be longitudinal so we can track over time and use throughout the community in multiple contexts
iii. DESSA mini is only 8 questions long and meets World Health Organization parameters
iv. Selected tools should be practical and help keep kids in Tier 1 and 2; Tools shouldn't take much time, money, or training

4. Final Comments
a. A skeleton outline of the rules will be presented at the next meeting for discussion

5. Closing / Next Steps
a. Public comment may be submitted to DPH at DPH.MCH@illinois.gov; Public comments will help create next agendas
b. Next meeting of this committee is June 22, and then regulations will be developed

Adjournment