

## **CT Family First - Governance Committee**

February 2, 2021 | 8:30 - 10:00 am

Microsoft Teams Meeting

### **Welcome and Introductions**

- Ken Mysogland and JoShonda Guerrier introduced themselves as the co-leads for DCF's Family First planning process. The plan for this meeting is to look at the recommendations of two of our workgroups, the 24-7 Intensive Treatment (also known as QRTP - Qualified Residential Treatment Program) workgroup and the Infrastructure, Practice and Policy (IPP) workgroup. Today's discussion will begin with the QRTP workgroup.

### **24/7 Intensive Treatment (QRTP) Workgroup**

- The QRTP workgroup is led by Dr. Linda Dixon and Dr. Alyssa Goduti. The purpose of the workgroup was to engage 40-45 stakeholders to understand system readiness. They began meeting in March of 2020 and finished their work in January 2021.
- The workgroup employed four taskforces within the workgroup to tackle specific issues related to QRTP.
- Family First has elevated the standards for residential treatment programs to receive federal funding. Effective 10/1/21, facilities must be considered Qualified Residential Treatment Programs. The requirements include:
  - Children will be assessed to determine if QRTP treatment is the right level of care to meet their needs
  - Increased court oversight of placement
  - Use of a trauma-informed model
  - Nursing and clinical staff accessible 24 hours/day and 7 days/week
  - Licensed and accredited by a certain national organization
  - Provision of 6-months of aftercare
  - Engagement with families as part of placement decision-making and ongoing treatment
- The workgroup looked at other states' strategies for incorporating these changes, and Connecticut is ahead of many states. There are some gaps, but we have historically invested well and are starting off on a better foot.
- We have many methods of communications and ways to exchange information.
- Linda and Alyssa shared their vision for residential treatment and strategies to achieve them (see Slide 7 of the PowerPoint). They also reviewed the preparation work and partner meetings (Slide 9).

- Linda and Alyssa reviewed the potential QRTPS, which include nine residential treatment centers (151 total bed capacity), 26 therapeutic group homes (135 bed capacity), and three per diem therapeutic group homes (15 bed capacity), for a total of 38 programs (301 bed capacity). STAR and PRTFs are **not** included in this calculation. Overall, these programs are underutilized and do not have backlogs; however, there are backlogs for specific populations, particularly for youth with autism and certain developmental disabilities. There are also backlogs in certain regions.
- The co-leads reviewed the workgroup recommendations (Slides 12-19). Some important points are below:
  - In terms of the **application process**, the application is currently too long. Elements are tracked quarterly.
  - Treatment documents should be standardized, and currently, the treatment has to be **assessed** if it is for over 12 months or out of state.
  - There should be **family team engagement**.
  - The **judicial review process** would not apply to families who are voluntarily utilizing these services; rather, it is only for children in DCF care. The court determining that a placement is not suitable does not mean that the child cannot be placed there, but that the state will not be reimbursed with federal funding.
  - Our **discharge/aftercare** plan is more robust than other states, which is good for children. It is important to continue the relationships for kids. The workgroup developed a matrix of varying levels of engagement depending on the children's need, which would be titrated over time. To accomplish this, facilities would reduce the workload for clinicians so that they can shift some of their focus to providing this aftercare.
  - There are many **workforce development opportunities**.
- The co-leads answered questions about the recommendations:
  - Q: How many families may need QRTPs?  
A: We have not had an overall backlog for the past few years, except for certain populations such as youth with autism or developmental disabilities. The state has shrunk its use of congregate care systems and hopes to enhance community systems to the point where congregate care is not needed.
  - Q: What is the timeline for the judicial review?  
A: A motion should be filed at Day 35, and it should be reviewed before Day 60. The Commissioner reviews this for children under age 12, and this information goes to Health and Human Services.
  - Q: How will readmission be affected by these changes?  
A: It will be decreased due to better support at every stage of the process.

- The co-leads reiterated the importance of language; specifically, they have been intentionally using the word "treatment" rather than "placement," because children should not be in QRTPs for placement but only due to treatment.
- It was suggested that while a child is in treatment, family therapy should be done with the family to ensure that the whole family is supported when they leave. This will improve what happens during treatment.
- Q: Has there been any thought to using existing systems for aftercare (e.g. mobile crisis check-ins, triage, etc.)?  
A: The workgroup did discuss this, but they feel the ideal situation would be care coordination that provides access to medical care. The QRTP itself needs to engage the 6 months of aftercare, not an external entity.
- One person wondered whether something could be developed that would allow a youth's information to be presented to multidisciplinary staff prior to discharge.
- It is also important to look at what is/isn't working; where could we have intervened (much earlier)? We should learn from the past.
- One provider spoke about Multi-Service System (MSS), which was a bridge back into the community. It consisted of team meetings between regions and providers to discuss system challenges, difficult cases, matches, etc. It was a critical way to connect families with services. It would be challenging to manage the case flow, but it is important to quickly connect folks with these services. With MSS, the group and decision-makers are all brought together to match services, keep everyone accountable, and provide clinical expertise. Decisions are made in the meeting.
- Alyssa added that planned respite is a current gap, and this would help families. Accreditation will also be a big lift, but it provides a standard level of quality that is beneficial.
- Q: How were racial/ethnic disparities addressed? It should be considered and integrated at the beginning, particularly when it comes to monitoring/best practices.  
A: There were robust conversations on racial justice, although this is not reflected in the slides. It has been an exciting part of the discussion, especially when it comes to individualized planning and family engagement.
- Q: 30 days for an assessment seems long - can you speak to that time frame?  
A: 30 days would be the upward limit; it would be before 30 days in almost all cases. Within the first few days, providers should be pulling treatment plans and assessments.
- In terms of next steps, there will be Ongoing Provider Forums (which all QRTP workgroup members are invited to), which will explore workforce development opportunities.

- Monitoring and support will be key moving forward; we have limited data right now, but this is an opportunity to gain more data which can inform workforce/development.
- Linda and Alyssa thanked everyone who participated in their workgroup meetings.
- To further the conversation on racial justice, it is true that there are racial disparities at all levels of congregate care, as well as differences in discharge reasons.
- One person explained that they have high hopes moving forward. Many places have great staff, and we are in the midst of a culture change for entry-level staff; however, many locations suffer from understaffing. This is in part due to poor pay at these organizations, which leads to great people burning out and other staff that remain not having the passion for the work.
- Alyssa agreed and hopes that appropriations will direct more resources to those workers by supporting organizations enough for them to provide wages that respect staff.
- Youth often request to stay in contact with their direct staff, which also helps with continuity of care.
- Michael Williams thanked the co-leads for threading the needle perfectly - we need to caution against the trend of complete elimination of this kind of care - we need to ask ourselves how we can appropriately use this level of care. Michael also liked the inclusion of youth voices.
- Linda added that nationally, congregate care has declined 40% in the last decade, and there is momentum to reduce it even more and possibly eliminate it entirely.

### **Infrastructure Practice and Policy Workgroup**

- The Infrastructure Practice and Policy workgroup took some time to share their work to date, review the themes and concepts they have uncovered, and receive feedback on their approach to their work.
- The workgroup so far has focused on the potential development of a care entity/community pathway(s) to service; screening and eligibility; and child-specific prevention plans. The purpose, process, results, and input of each of these focuses is summarized in Slides 27-35.
- The workgroup reviewed its gaps and challenges.
- Connecticut was ambitious in its candidacy definition; while many states took a narrow focus and included traditionally DCF-focused populations, we took a broad approach that includes community pathways to reach families sooner, further upstream than their current interactions with DCF. Our challenge now is to create a system that will work for both community pathway families and DCF-involved families. This is difficult because we must navigate the system as it currently is, while building the potential future state.
- The workgroup agreed that the new system should not be the current system. There are many potential referral sources, including 211, town social services, the Careline, support

groups, and other care management entities. The workgroup has struggled to move forward without knowing which of those the system will hinge on - we also need to do this for CQI/data elements.

- It would be helpful moving forward to have confirmation that this system should reside outside of DCF.
- The workgroup broke into smaller subgroups, and the large group will be back together next week.
- They have also struggled to get families to the table. To combat this, a series of community conversations are being planned that will bring families with lived experience together to discuss their experiences. Their feedback will guide the workgroup's preliminary recommendations.
- One member suggested using these slides (or similar slides) in the focus groups.
- Another person pointed out that although we are aiming to take a family approach, we are also in a silo by only focusing on children. Family success comes from building up the adults - we should consider expanding pathways to include those that are involved in adults' lives. For families to self-refer, they must be aware of what is available.
- Michael Williams had two questions: 1) Can we expect an outcome of reduced reports? 2) How will data collection and reporting be handled? Would they be the owner of the data but not the collector? If so, we will need to build a system for that data through PIE, CT-KIND, etc. DCF does not need to capture it all, but we do need it for claiming purposes. JoShonda answered that yes, this should lead to a reduction in reports as the prevention would divert families from the child welfare system. For question #2, CQI is part of the work, but we are not at that point in the discussion yet - so far, the workgroup has focused on the beginning of the system. Michael wondered whether the reduction in reports should be a part of the messaging.
- A workgroup member emphasized the importance of family engagement and was thrilled to see that it is a big focus - everyone needs to be involved for this to be successful.
- JoShonda asked the Committee for their thoughts on having the prevention entity sit outside the Department. Several members shared their thoughts.
  - DCF has made strides in partnering with the community - if this entity is separate, does this put DCF back in the "bad guy" position?
  - There needs to be alignment between families internal and external to the Department - we want to see the same outcomes and approach. The idea of a separate care entity came through dialogue, although many particulars still need to be worked out.
  - If there is not money currently free to create a new system, we would request funding be made available.

- Given that there is a separate entity that manages behavioral health already, is it possible to have one entity that does both? JoShonda explained that this was considered, but the conversations have been difficult - for example, Jeff had to recuse himself from those conversations due to his position with CHDI. We do not want the decision to be made due to special interests, nor do we want any question of whether special interests influenced the process. The group has considered this and is open to an existing entity and having one overarching entity would be easier for families. It could then be localized. The group was uncomfortable choosing a specific entity. DCF to discuss further.

### **Communications Strategy and "Parents as Experts" Conversations**

- Ken and JoShonda joined the SAC (Statewide Advisory Council) meeting on 2/1/21 to discuss the two convenings that will be held to gather family feedback.
- They are also working on presentations to update the SAC and RACs on the workgroups' progress and recommendations to date.
- Casey Family Programs has been assisting with branding and messaging.
- Ken and JoShonda are also willing to present to organizations.
- It was suggested that they go to the Youth Advisory Board (YAB) to gather youth feedback, as well as other youth groups such as CCA, Compass, and OPP.

### **Closing Thoughts and Next Steps**

- Michael Williams acknowledged the tremendous amount of work done by Ken, JoShonda, and the Chapin Hall staff. "I can't say thank you enough," and he was appreciative that despite COVID, we are on track to submit our plan for April.
- Commissioner also thanked the co-leads and everyone that has been involved with the process. We are at the point where Governance will begin finalizing recommendations. We now face the bigger work of building a broader prevention array outside DCF, moving systems, and imagining what Connecticut should look like outside the current system. We must remain open and willing to challenge ourselves, as well as be critical of our own systems.
- The next Governance Committee meeting will be **Tuesday, March 2 from 8:30-10:30 am** over Zoom.