Minutes
Family First - 24/7 Intensive Treatment (QRTP) Workgroup
Meeting Date: January 8, 2021 | 1:00 - 2:30 pm
Zoom Meeting

QRTP Workgroup

- Discussed workforce development opportunities
- Family engagement and trauma informed practice are workforce development issues
- Building Bridges work - might be helpful to us as a group
- One person asked, is this cost neutral? Running congregate care facilities requires capital. Alyssa Goduti agreed that it might be good to take a look at capacity and planning questions like this. Linda Dixon added that fiscal questions are important and complex. Right now, Connecticut is at around 5-6% congregate care usage; best practice is around 10%, so we are currently exceeding best practice. It would be better for providers to know what the needs will be so they can better plan for the future. Ken suggested discussing statistics/size mapping later and shift to workforce development.

Workforce Development Opportunities

- There are several goals for workforce development: trauma-informed, culturally competent, well-versed in family engagement, and capable of working with kids with disabilities and co-occurring mental health issues.
- One person suggested considering the role of parent partners and people with lived experience – what roles/positions could there be for them in the workforce?
- Linda highlighted the importance of trauma-informed practice outside of therapy. The workforce needs to learn more from others and be trauma-informed with an equity lens.
- The California Clearinghouse has a category for alternatives to long-term treatment (CARE, Sanctuary, DBT) that some folks are excited for. The ARC model is the fastest growing, and some have asked for more information on the practice. One person who is familiar with the model offered to share research if folks were curious.

Aftercare

- One suggestion to address the fiscal concerns was to lower bed capacity, and use the money saved there to provide aftercare services. If capacity is reduced from 5 to 4, this would add capacity for aftercare. Funding is something to discuss more deeply with fiscal. The workgroup developed a fee-for-service rate and spoke with fiscal; it cannot be cost-neutral, and they would need fiscal support, but the workgroup wants something robust and individualized – more than just a phone call (although they could fall back on this if necessary).
  - One workgroup member had concerns about this solution, as facilities need flexibility for things that are not on the schedule. In group homes, things come up. This concern was responded to because if a clinician’s caseload is reduced, then aftercare would fill the extra time.
  - Linda explained that each youth needs an aftercare plan; to fund this, they would reduce the number of beds. Without this possibility, we would need to have phone calls be the method of aftercare, but the group wanted something more substantial.

- Ken asked if the Aftercare group could review their plan for the broader group. Linda shared that they created a grid with tiered models that level out depending on need. There is care coordination, and the family will continue to engage in services. The care is done by care staff or a clinician, but it should be tailored to the child's needs. Another member added that it depends on the level of care and allows for flexibility. They also liked the fact that it is not necessarily the clinician that provides the care, as it should be provided by someone who has a strong connection to the child. Staff like the idea of continuing care, and Alyssa added that it is a good idea to have services taper rather than firmly cut off.

Family Engagement

- This group has continued to consider how to best support family engagement and make families feel comfortable and connected. Currently, community is not expected, there is just a hand-off that sometimes does not go well. They hope that funding will ensure that it happens better.
- The group discussed family engagement vs therapy – families should have access to advocates that will help ensure the child has a better chance of not having to go back to that level of care.
- There are language and cultural barriers to access to advocate.
- The group liked the idea of those with lived experience participating, but there is still the question of how to make those connections happen. It would also be great to have someone with dual experience who really know the ins and outs of the system.
- One person suggested something akin to the AA model, which creates a network with a per diem model. This way, folks with lived experience are employed in the process and can give back while balancing their lives.
- The concept of family engagement should be expanded to include kin and extended family – who is supporting this youth? Who can play a role in their life (not necessarily as a placement resource, but just in terms of support)?
    - ➢ One person pointed out that there are often challenges in the family system that mean some family members cannot understand the illness. These members may need therapy-informed information, otherwise they can undermine the therapy. For example, an aunt/uncle who do not understand early childhood trauma may have a different opinion on how to raise the child, which could make for mixed messages. It is important for them to understand the therapeutic reasons behind some of these decisions. That being said, it is challenging and expensive to involve more people, and it is hard for providers to serve families in this way – we would possibly need another billing model.
- Linda suggested gathering more data to better see the patterns in the system, especially as it relates to waitlists and workforce development. We do not want to burden providers.
- Alyssa agreed that it would be helpful to know where needs are to create a QI process and develop new skills. Beacon would be a good resource for gathering data.
- One member added that their site looks at data due to backlogs. We should also track clinical outcomes to see whether aftercare is effective. The group agreed that this data is important.

Other Updates for the Governance Committee

- The workgroup was asked to share any other considerations that should be brought to the Governance Committee.
- One person asked whether there has been any discussion around the lack of ongoing respite. This is an ongoing issue for families with youth who have developmental disabilities. Some families need planned respite to keep their energy levels up, and this must be individualized for the family. Right now, this is only available on a crisis basis, which compounds trauma. Everyone needs support and a break. This has been talked about, yet we have failed to act on this in Connecticut. This also needs to include expertise on certain conditions and age flexibility.
  - ➢ SFITs can be planned, and they may have the beds for respite.
  - ➢ It was suggested that we look for data on how this would help and consider making it a part of discharge planning too.
  - ➢ Planned respite should be in a familiar location that is comforting to the child.

Next Steps

- The workgroup will be sent a summary of the recommendations and be able to provide suggestions or feedback over email. Linda Dixon and Alyssa Goduti will review the recommendations, adding in the workforce development and respite discussion points. A summary will be distributed to the group, and it will be further refined in the provider meetings.
  - ➢ Anyone in this workgroup is invited to join the provider meetings, which occur every other month. Several members asked to be added.
- With that, the QRTP workgroup was sunsetted.
- Ken Mysogland explained that the Governance Committee will listen to the recommendations of the workgroup and discuss them in detail. They will then provide recommendations to Commissioner Vannessa Dorantes. The Programs and Service Array workgroup, as well as other workgroups, have already presented their findings to this Committee.
- All the QRTP workgroup has discussed will be presented to Governance (probably at a February meeting), and then the Committee will discuss it and the Commissioner can approve it. We are moving closer to formal approval.
- The plan is to have the Family First Prevention Plan approved internally and submitted in April 2021. After that, we will move to implementation. We will see iterated plans throughout until the submission to the feds.
- Linda committed to sending out an invite to the provider meeting to the members who requested it, and Ken thanked the workgroup for their consideration at both the broad and narrow prevention levels throughout this process.