CHCS Center for Health Care Strategies, Inc.

New Jersey Children's System of Care Stakeholder Convening

Made possible by Casey Family Programs

December 4, 2019
Department of Children and Families
50 East State Street, 2nd Floor Conference Room, Trenton, NJ 08608

Meeting Minutes

Participants

Stakeholders: Megann Anderson (NJ ACYF), Suzanne Buchannan (Autism NJ), Cherie Castellano (Rutgers UBHC, Mom 2 Mom), Michael Dallahan (Partners for Kids and Families), Anthony DiFabio (Acenda Integrated Health), Rachel Helt (Family Partners of Morris & Sussex Counties), Connie Greene (RWJBarnabas Health), Vera Sansone (CPC Behavioral Healthcare), Ramon Solhkhah (Hackensack Meridian SOM, JSU Medical Center), Peggy Kinsell (SPAN), Dawne Lomangino DiMauro (AVANZAR), Kathleen Noonan (Camden Coalition), Debra Wentz (New Jersey Association of Mental Health and Addiction Agencies, Inc.)

DCF: Mollie Greene, Loletha Johnson, Diana Salvador

CHCS: Melissa Bailey, Sarah Rabot, Pamela Tew

I. **Welcome, Introductions, and Purpose**
- Facilitators reiterated the convening structure, describe ground rules and roles of participants in the process.
  - Ground rules:
    - Listen to understand;
    - Respect diverse perspectives;
    - Stay on topic… or use the parking lot; and
    - Lean toward solutions
- Assistant Commissioner Greene described the purpose of the convening series was to emerge with a clear set of priorities for CSOC to work on.
  - We want to think broadly about next steps. Some of the strategies that we will discuss are more narrow short term goals and others are larger scale system reform efforts.
  - We also need to think about how we demonstrate success and focus on what the desired outcomes are.
  - Of course, there are real financial pressures that will impact how the division moves forward on implementing strategies.
- Participants introduced themselves and shared any thoughts or questions they had since the last meeting:
  - How long with the email address for feedback be up on the CSOC website?
    - It will be up as long as is needed. CSOC is encouraging feedback and input related to this process.
  - Participants communicated that they enjoyed the resources provided through the meetings and the structure of the sessions.

II. **Identifying Emerging Themes and Prioritization of Strategies.**
- Prior to this session, participants were given a list of themes and associated strategies to address system issues that emerged from the first three sessions. Each person had the opportunity to vote for 3 strategies in each category that they thought would have the biggest impact. CHCS then took those strategies and provided a handout (*available on website)* that was used as a framework for further discussion and related decision making.
- Each strategy has a number and letter associated with it for tracking/identification purposes. During this session, the group discussed each strategy, identified the desired outcome if that strategy were to be implemented, and then used a prioritization matrix to determine both the level of impact it would have and the level of effort it would take to implement.

- Below is a review of each strategy and the applicable discussion (the prioritization matrix is at the end of the minutes and shows how each strategy was plotted):

Promoting integrated health and behavioral health: **Develop a more upstream / prevention-oriented approach by partnering more effectively with other child-serving systems**

- 1A: Engage in a process to do a full system mapping process—crosswalk with full continuum of child and family need and response to need (prevention through high-end treatment needs).
  - Doing the initial mapping is relatively easy compared to the difficulty of maintaining it over time.
  - It is critically important though to do this prior to implementing other strategies.
  - Including services outside of CSOC is important and county-led services and initiatives should be included as well, as we need better coordination.
  - Measures of Success:
    - Mapping completed
    - Sustainability plan
    - Identification of gaps and needs

- 2A: Better coordinate with pediatric providers: - ACEs screening/SDOH Screening/Family Assessments – Establish process to connect children who screen high in pediatrics directly with CSOC – Leverage the current pediatric learning collaborative for provider education, training, and navigation.
  - We need to determine what is best practice and then think about how to implement requirements.
  - Need to think through how to support pediatricians in knowing what to do after screening, specifically when it comes to SUD and I/DD.
  - It's about changing expectations and normalizing things as well.
  - Measures of Success:
    - Established screening best practices
    - Greater partnership with Pediatric Collaborative – able to leverage this relationship and use technology more efficiently to drive adoption of best practices

- 3A: Develop MOUs between child-serving systems to create clear protocols for coordination and shared responsibilities.
  - Attention needs to be paid to the impact MOUs will have on system functioning. Some get baked into organizational culture and some get ignored.
  - Also important to look at what MOUs already exist and inventory them.
  - Measures of Success:
    - MOUs to address cross-departmental coordination exist and are baked into practice
    - There is regular review of MOUs and impact

Promoting integrated health and behavioral health: **Develop a more upstream / prevention-oriented approach by providing families with more holistic services and supports**

- 4A: Establish mechanism to better support caregivers: - Treat families holistically – Address parent functioning in the context of children's behavioral health services – Support needs of parents of children with I/DD – Develop services to address co-occurring needs of children with I/DD and behavioral health needs
  - 1A will dictate what is already happening for families.
  - Focus should be on fostering resiliency in parents.
  - It is critical to include the medical community.
  - Measures of Success:
    - Consumer satisfaction: track who is calling and why they are calling
    - Decreased utilization of emergency services
    - Reduction in specific types of referrals that come in due to a lack of support

- 5A: Invest in workforce development: - Collaborate with Medical schools, other health professional programs – Train system partners together – Continue to develop capacity to be culturally competent (NJ is extremely diverse) – More training for co-occurring issues – Modernize child development training – Integrated training

for peers and clinicians –Sustainable and continuous training for a rapidly changing workforce – Motivational interviewing training for "front door" workforce.

- There are, in a sense, to issues here. 1) Workforce training and capacity to deliver quality services and 2) Investing in addressing adequate and appropriate compensation for the workforce. The second is almost a baseline issue.

- Measures of Success:
  - Increase in staff retention
  - Appropriately sized caseloads

Promoting integrated health and behavioral health: **Utilize Medicaid authority to develop programs that fill gaps in service array**

- 6A: Think about how different Medicaid authorities (waivers, state plan benefits) can be used, potentially braided with other funds, to develop new services needed to fill gaps.
  - Some of will be a natural byproduct of 1A.
  - Need to think about how will system map look different and what funding mechanisms are available to support that change.
  - Measures of Success:
    - Understand what will be most effective (e.g. most impact for smallest investment)

- 7A: Develop Emergency Room alternative for youth needing immediate attention for behavioral health needs
  - Mobile response doesn't have all the resources it needs.
  - There needs to be an option for families who really need a place to go that meets their needs.
  - Measures of Success:
    - Children not ending up in the ER for mental health crises
    - Increased understanding/awareness of mobile response
      - Understanding of populations it doesn't work for
- 7B (MOVED AND CONNECTED TO 7A): Improve training for crisis response for youth with I/DD
  - Connected to 7A
- 8B (MOVED AND CONNECTED TO 7A): Better coordinate with other systems interacting with children with I/DD and their families—better transitions/hand offs needed

Promoting integrated health and behavioral health: **Build out service array for children 0-5**

- 8A/9A: Utilize 0-3 Autism Screening Tool and social/emotional screening tools/ Develop service categories for children under 5: - CSOC should serve children under 5 with serious emotional needs (focus on foster care population and children at risk for child welfare involvement) – Infant Mental Health services for CMOs and FSOs to access
  - Connected to 4A
  - There is confusion in the community if CSOC serves children under 5 – need to ensure families know where they can access services for young children.
  - There are children who do have behavioral health and mental health needs whose needs could not be met through Early Intervention. What are the services that we could have or could create that would be more appropriate.
  - We are serving some kids under 5, it's a small number.
- Measures:
  - Assess gap for 0-5
  - Proportionate screening and diagnosis and access to autism services
  - Examine clinical criteria and increase available services (and recruit appropriate workforce) for children under 5.

Build capacity to deliver evidence-based and best practice interventions: **Increase the use of services that achieve positive outcomes**

- 1B: Develop mechanisms to assess "service need" vs. provider capacity

- Combine with 1A

- 2B: Establish quality measurements and utilize a standardized tool to collect measurable outcomes for all system providers
    - We need to look at Data and assess what we can glean from there. What quality measures do we want to be looking at?
    - Want to make sure measures align with DCF's vision and values and includes satisfaction.
  - Measures of Success:
    - Be able to present a standard set of quality measures to present for the local system as well as for different service elements within that system.
    - Paying for services that achieve quality outcomes
    - Having an understanding of how to use data we have

- 3B: Map EBPs and promising practices within the state: - Establish differentiated rates for EBPs and non-EBPs—Alternative Payment models may be an option
    - Step one is to do the mapping, step two is to figure out how to pay in a way to incentivize how you want the service array to look like in terms of EBP utilization.
    - Family First legislation comes with a framework for determining promising, supported and well-supported practices.
  - Measures of Success:
    - Accurate mapping of EBPs that includes credentialing information
    - Connect with rate-setting work happening
    - End product of network database

Build capacity to deliver evidence-based and best practice interventions: **Improve the contracting process related to procuring service providers**

- 4B (4B WAS SPLIT INTO TWO): Evaluate procurement process: - rethink contracts that better ensure sustainability and availability of programs: - are multi-year contracts an option? – roll-over contract funding into new FY
    - Part of this has to do with taking a hard look at contracts the department has, ensuring there are outcome criteria and services are achieving the intended results.
  - Measures of Success:
    - 4BA: Using data to drive contracting decisions – outcome criteria and intended results
    - 4BB: Needed services are sustainably funded

- 5B: Thinking about blending funding streams where appropriate to increase services and supports and consider alternative payment models to create useful flexibility
    - Tied to 1A

Build capacity to deliver evidence-based and best practice interventions: **Evaluate services and supports to families of children with I/DD**

- 6B/8B: Increase "supports"—broaden the idea of what families beyond "services" – More "normative services" outside CSOC. – Do a deep-dive in Family Support Act related services – Increase respite and skill building for parenting a child with I/DD / Better coordinate with other systems interacting with children with I/DD and their families – better transitions/hand offs needed
    - Need to address confusion with family support act
  - Measures of Success:
    - Families are getting what they need throughout each life-stage
    - Concrete supports are adequately resourced

***Enhance CSOC capacity to ensure equitable access*: Increase understanding of how disparities (race, class, gender, sexual identity) impact the system structure and services to families**

- 1C/2C: Develop a way for CSOC staff and system partners to talk about implicit bias and how it impacts the system and families and identify ways to address its impact - Provide training on implicit bias, equity and the importance of collecting demographic information and documenting it appropriately - Use demographic data to identify disparities and develop strategies to reduce them
    - This is a conversation that has not been happening in a robust way throughout CSOC and it needs to be prioritized.
    - Utilizing data is an important component so the system understands where to intervene.
    - The first step is to ensure demographic information is entered for those that utilize services, but also to begin raising awareness and understanding of implicit bias and its impacts.
    - There is both an internal CSOC portion to this and external/system partner component.
  - Measures of Success:
    - Increase access to/utilization of demographic data
    - Decrease disparities in access to services
    - Increase positive outcomes

***Enhance CSOC capacity to ensure equitable access*: Reduce the complexity of the application process for children with intellectual and developmental disabilities**

- 4C/5C: Help families navigate the system and application process – have single point of contact – have coaches/mentors available as navigators – information sessions – online application tutorial models/reduce number of reports needed for application
    - This is something CSOC is already starting to look at and very much wants to address.
    - It is important to be clear with families about what they should expect to receive as a result – there can also be a downside to this, but the feeling is that better setting expectations should be a goal.
  - Measures of Success:
    - Families knowing where to go and get the help they need
    - Families feel the application process is clear and they understand how to find help when needed.

***Enhance CSOC capacity to ensure equitable access*: Evaluate Substance Use Disorder service array and access**

- 7C/9C: Raise awareness of available services - Create a single point of contact for SUD services
    - It is very important to pay particular attention to SUD services in the mapping process – when SUD services were transitioned to CSOC, it felt like "services were lost."
    - Also, there is a lack of services available for co-occurring SUD/mental health, which is a huge need.
    - It hasn't felt like SUD services were fully integrated into CSOC.
    - The referral flow for youth presenting with substance use service needs is not clear to families and system partners.
    - There were reasons for this related to how the transition of SUD services to CSOC, but there needs to be attention paid to where the access points are and adjust as necessary.
  - Measures of Success:
    - People know where to go to get help (other professionals and families/youth)
    - Youth aren't excluded for co-occurring SUD

- 8C: Increase services providers ability to deliver more individualized services

- Youth often need services that are very tailored to their needs and the needs of their families. It is not one size fits all.
- This is a workforce capacity issue and a service structure and capacity issue.
- CSOC is very committed to addressing this area.
- There are legal barriers to youth and families receiving support (youth can refuse treatment, confidentiality) and often engagement strategies fall short, leaving families with the feeling that they have nowhere to turn and no support for getting their children help with SUD.

- Measures of Success:
  - Services are effective and there are a variety of options to meet different needs

III. **Debrief**

➢ CHCS will be developing a report following the full convening series outlining what was heard and providing a set of considerations for DCF.