CHCS Center for Health Care Strategies, Inc.

New Jersey Children's System of Care Stakeholder Convening

Made possible by Casey Family Programs

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

Meeting Minutes

Participants

Stakeholders: Megann Anderson (NJ ACYF), Cheri Castellano (Rutger 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), Deborah Spitalnik (RWJMS/The Boggs Center on DD), Cecilia Zalkind (Advocates for Children of NJ), Peggy Kinsell (SPAN), Ramon Solhkkah (Hackensack Meridian Health), Dawne Lomangino DiMauro (AVANZAR), Kathleen Noonan (Camden Coalition), Debra Wentz (New Jersey Association of Mental Health and Addiction Agencies, Inc.), Fred Simmens (Casey Family Programs), Edwin Lee [by phone] (Juvenile Justice Commission)

DCF: Mollie Greene, Christine Idland, Melinda Carnassale

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
- Participants introduced themselves and shared any thoughts they had since the last meeting.
  - Some participants shared that they were appreciative of the opportunity to participate and enjoyed the previous meeting.

II. **Level Setting**
- Assistant Commissioner Greene reiterated the vision of the future of CSOC and desired outcomes for the series of convening.
  - This work aligns with the broader vision and direction of DCF as a whole.
  - We have this opportunity to think about where and how we can improve. What are the opportunities we have missed or have not explored to improve the health and social emotional wellbeing of children in NJ.
  - We have identified three broad priorities to get us there with the first one being integrated health with an emphasis on coordination with primary care to support early identification and intervention. Today we are discussing the second priority and considering how CSOC might improve utilization of evidence-based practices. It is important to start with what is now available, if and how we would expand availability, and what other EBPs we should consider supporting within CSOC?
  - We want to think not only about proven models of treatment, but also other best practices can be employed. Not all EBPs are a good "fit" for individual youth and families.
- Participants reflected on Ms. Greene's comments:
  - We need to think about the social determinants of health and how these effect people. There are things beyond what CSOC does that deeply impacts people's well-being. There needs to be coordination with other systems.
  - System partners often know what the solutions are, but don't necessarily have the time to devote to really support families.

        - Ideally this process will include figuring out how to make access and getting needed supports more streamlined and free up time for system partners by creating a more coordinated system.
    - EBPs are excellent, but sometimes we get caught up in maintaining fidelity rather than focusing on outcomes and serving people. There is a disconnect between ideologies/academic model and what really works in practice.
    - Another barrier for EBPs is the cost.
        - It is important to think about what is the outcome. There have been a lot of dollars spent on evaluation for fidelity to a model where there was no data on actual outcomes related to the families actually served.
        - Our capacity to deliver services in the community is so important. IIC (intensive in community services) is a good example - it was intended to be a short-term service, but it is not clear how the 3-month duration of services was established as a standard. We hear folks saying a youth just engaged with their in home therapist after 6-8 weeks and there may not be consideration of the need to extend beyond 3 months to accommodate this.
        - We're not necessarily talking about services costing less (in-home, residential, etc.), but want to focus on quality outcomes.
    - Workforce is critical. We can talk about EBP interventions but if we don t have enough workforce to implement, it won't work.
    - Critical things to think about are training, fidelity measures, and appropriate reimbursement.
    - Accountability is critical as well – are providers delivering what they promised?
        - Are there outcome measures that can show that?
        - Are the outcomes we've long articulated for Behavioral Health right for children with I/DD. What should that look like?
    - There is an inevitable tension to consider with the realities of urgent presenting needs (behavioral crisis, children expelled)
- Facilitator reminded participants that when we get into the brainstorming we should be thinking about solutions in 3 buckets – policy, practice, and financing - those are legs that support EVP.

III. Identification of System Strengths and Challenges

- Participants were asked to identify both strengths and challenges in the children's system of care related to EBP utilization.
- Identified strengths included:
    - Statewide children's mobile response;
    - Pockets of MST and FFT;
    - Maternal health home visiting programs in every county;
    - Wraparound and Child Family Team process has delivered positive results for families and communities;
    - A system that no longer relies on out-of-state placements;
    - Residential array overall is working well – there is a clear process and selection criteria that works to get youth into the right program;
    - In some ways, PerformCare is a strength. Having centralized access is good especially when you compare it to the adult side where there is none.
    - Leading the country in peer support;
    - CSOC has a tolerance of experimenting and doing things differently with goal of getting evidence at the end;
    - Lucky to have nonprofits that are invested;
    - Parity legislation federally and more models of what parity looks like. We know a baby needs to be seen 10 times before the age of 3 - we do not know what those 10x would mean for mental health. What would that look like? Anxiety, depression and suicide are in the air, you can no longer avoid it. It's a great opportunity to say this is the century when we figure out what would be the equivalent of a vaccine for these issues so that we know that their attachment is good and so on. Those are strengths that we should build on;
    - CDC says our autism tracking is leading the nation, but we don't use the data in a meaningful way;
    - Resiliency training. Unique to have people interested in our state who are wanting to build on resiliency.

- Out of home care services are strong. Having a more detailed conversation around who is doing a great job and use them as a model;
- Family First implementation efforts;
- With CCBHC we've been able to do in home that were never able to do before. Preconception at the beginning of the system was that CCBHC - Think there are opportunities if you have a waiver program to look at integration in new way.

➢ Identified challenges included:

- There isn't uniformity of opinion in terms of EBPs for autism;
- When kids are in residential, there is drop off in intensity of services when they leave residential which is inadequate for children.
    - It would be great if we had the same capacity around selection for community-based services as we do for Residential – we don't necessarily have a great way of "vetting" credentials and what treatments they provide;
- Transportation for families is a barrier;
- Workforce capacity is a challenge. There are costs to train people and there needs to be oversight in terms of fidelity;
- Accountability is an issue in various ways within CSOC. Are providers really providing what they say they are?
- Budgeting is a challenge because state dept. budgets are siloed;
- Home rule is a challenge;
- There is a lack of coordination with other BH services that serve kids outside CSOC system
    - CSOC doesn't need to own everything but need to connect and support;
- Coordination between DCF and DOE can be a challenge;
- Application into PerformCare is still a huge barrier to families with I/DD children;
- Increased supports for caregivers of children receiving services are needed;
- We don't have complete data and a clear definition of success. Need a framework and system to be able to plug that into.

IV. Brainstorming Opportunities for Progress

➢ Next, participants broke into groups to begin generating ideas to move the system forward as it related to EBPs. Participants were asked to be bold, to be as concrete as possible and to focus on the "how" of each idea.

➢ Ideas were bucketed into 3 categories: 1) policy Ideas, 2) practice ideas, and 3) financing ideas**.**

➢ Participants came back together and shared the ideas generated, they included:

- **Policy**
    - Create waivers (state waiver) to establish a more integrated approach and allow community providers to get reimbursed by and connected to CSOC;
    - Learning from other states;
    - Examine Medicaid requirements that impact service provision;
    - For youth going into Juvenile Justice, suggest being able to continue with the same IIC provider and not have their service cut;
    - Look at Screening bill - Current law doesn't speak to screening for kids which leads to inconsistency;
    - Do not want kids in ER with adults;
    - Improve training for crisis response on youth with I/DD;
    - Data-driven planning;
    - ACE score work for pediatricians;
    - Expand CSOC to serve children under 5 with serious emotional needs who are not served in other system and start with children in placement. This age group represents 50% of kids in foster care placement;
    - Standardized tool to collect measurable outcomes for all system providers;
    - Improve use of Data Science;
    - Utilize 0-3 autism screening tools;
    - Expand early intervention system to at risk children.
- **Practice**

- Redefining what a tiered step down looks like;
- Replicating out of home selection process for IIC providers, which includes vetting providers and seeing what their credentials are and what interventions they do with additional oversight;
- There are providers/programs that are doing a great job. We should figure out who is succeeding and highlight their success and use them as a model for others;
- We should create stronger linkages with non-CSOC services;
- More interaction with schools so they are aware of CSOC services;
- Having a process to mapping all EBPs and promising practices within the state;
- Mapping service trajectory;
    - What does the journey of care look like in CSOC?
- Think about a single point of access for all BH services;
- Improve data collection;
- There is a need to develop a shared language across administrators, providers and children and families. We need to incorporate a standardized language that is family focused;
- We need to standardize the model of collaborative communication for the continuity of care;
- Expand to serve children under 5 with serious emotional needs starting with kids who aren't served in other systems;
- Standardize the use of the CANS across the state so providers would be talking the same language across different systems;
- We need functional approaches to access to services, not just clinical judgement, meaning specific diagnoses and/or assessments;
- There needs to be better transitions/hand off of young people living with I/DD related to departments, education etc.;
- Currently, CMO must close out if they are referring to FFT. Does this need to stay in place?
- Investigate and assess early intervention system to see if what they are doing is meeting the social and emotional needs of children;

o Finance

- We need to blend and braid funding to support comprehensive services;
- Revisit contract structure – currently EBP and non-EBPs receive the same rate;
- Think about use of global budgets;
- Investment in navigation/coordination for families;
- Get the national perspective on what to do/not to do and lessons learned;
- Utilize EBPs approved for other states under FFPSA;
- Look at CSOC capacity to manage complex data systems and fulfill its mission, etc. – may need to be increased resources there;
    - Example: Washington State has made an investment in data science in their Medicaid office
- Holding commercial payers responsible for their portion of the cost of services;
- Look at establishing infrastructure building grants from state/feds to providers
    - Very hard for providers to invest with current reimbursement structures;
- Look at public/private partnership for QI work in the state;

V. **Debrief**

- Ideas generated at this and sessions one and three will be brought back for further consideration and discussion at session four.
- CHCS will be developing a report following the full convening series outlining what was heard and providing a set of considerations for DCF.