

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), Suzanne Buchanan (Autism NJ), 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)

DCF: Mollie Greene, Katherine Stoehr, Christine Idland

CHCS: Melissa Bailey, Sarah Rabot, Pamela Tew

I. Welcome, Introductions, and Purpose

- Facilitators introduced 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
 - Commissioner Beyer shared the vision of the future of CSOC and desired outcomes for the series of convening.
 - Following the Commissioner's listening sessions around the state, it was clear that additional work is needed to make sure the system works for everyone.
 - This group was asked to help the Department think through how to address some of the challenges that currently exist.
 - This is part of DCF's larger strategic plan implementation and is just one step in helping the system to continue to progress and better serve children and families.

II. Level Setting

- Facilitator introduced the topic for the session—promoting integrated health and behavioral health. Participants were reminded that the goal of this convening series is to have CSOC system stakeholders to be thought partners with DCF in thinking about how to continue to improve the system of care.
- Ms. Greene shared DCF's goals for better integrating care within the state. She provided the following context:
 - It is important to deliver care using a multidisciplinary approach – there's always some physical component or dimension.
 - There are many opportunities for us to integrate care, for example in pediatrics and building on what is happening in behavioral health homes.
 - The success of the behavioral health home model in NJ has been very dramatic because they are working with adults with complex medical and social needs. For children, however, the behavioral health home could be more prevention focused.
 - It is important to have strong partnership with the physical health system.
 - We are hoping that in the next few years we can say these are the things DCF will focus on that will have long lasting benefits beyond pilots and interventions.
- Participants were encouraged to bring innovative ideas to the group and to talk to their constituencies and system partners to bring additional ideas to the group.

III. Identification of System Strengths and Challenges

- Participants were asked to identify both strengths and challenges in the children’s system of care that would illustrate particular pain points and gaps in care.
- Identified strengths included:
 - State leadership that understands that there is still work to be done to meet the needs of children, youth and their families and is willing to bring stakeholders together in this way;
 - In some ways, the system has a culture of collaboration and is filled with rich expertise;
 - The system values parents and parent advocacy;
 - Strong partnerships within the system;
 - CSOC has a single point of entry which can eliminate confusion over access and is responsive to the needs of families through MRSS and fast, telephonic engagement; and
 - The system is data informed and trauma informed;
- Identified challenges included:
 - The system works well for certain people with certain needs, but there are variations in access to services based on geography and also on presenting conditions;
 - While collaboration happens between particular parties, more can still be done to collaborate between agencies and state departments and also communicate more effectively;
 - There are gaps in knowledge and practice models between physical and behavioral health;
 - The system tend to be child centered and doesn’t always meet the needs of whole families;
 - It can still be difficult to engage families due to stigma and other obstacles – we need to work harder to engage families;
 - While the system has done a good job of being trauma-informed, more work can be done to be more trauma-responsive;
 - There is a lack of service to children under age 5;
 - Timeliness of accessing needed services can be a challenge;
 - There are disparities that exist within the system – racial, regional; immigration status;
 - System partners such as schools and primary care providers don’t always know how to help families access CSOC services;
 - Child and Family Teams are not always comprehensive;
 - Transition-age services are not robust enough;
 - A shortage of Psychiatric Care Providers;
 - Sometimes conflate the idea of services vs. supports – especially for children with disabilities, these are distinct concepts; and
 - Procurement models can limit how programs are developed and maintained;

Comment: How do we create resilience and excitement within providers? How do we empower people who are doing this work? This is an opportunity to inspire people but have to develop a new ethos for CSOC.

IV. Brainstorming Opportunities for Progress

- The stakeholder group was asked to identify elements of an ideally functioning system – responses included:
 - Children wouldn’t end up in the emergency room;
 - Children and families would receive the “right” service at the “right” time;
 - Family friendly services would be available 24/7;
 - Families and system partners would know exactly where to go to get help in a crisis;
 - There would be “no wrong door”;
 - Services would serve the whole family;
 - There would be the idea of treating “community mental health” – communities would have support following a traumatic event;
 - Services would be truly collaborative and available adequately across the state;
 - Pediatricians, nurses and primary care providers would be educated about children’s behavioral and developmental health and know how to easily refer children for CSOC services;
 - Workforce would feel “empowered” and “inspired”;
 - Services would be outcome driven; and
 - There would be solid public/private partnerships.

- Next, participants broke into groups to begin generating ideas to move the system forward as it related to better integrated care. 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**
 - NJ could potential form a “children’s cabinet” to have a venue for better cross-system collaboration
 - It is important to connect with other systems who are having similar conversations elsewhere;
 - MOU’s could be developed between entities that engage children and families (schools, police, DCF, DHS, DOH, etc.) to create clear protocols for coordinating when an issue arises with a family;
 - Early intervention – expand to “at-risk” children and make high lead levels an “at-risk” category for services
 - Alleviate burden on EI system by partnering more effectively;
 - Develop service categories and increase focus on ages 5 and under
 - Early identification and treatment linkage;
 - Utilize SBIRT for youth in primary care and other settings;
 - Map all services available to children and families to better understand the full service continuum;
 - Establish a process to connect children/families who score high on screens in pediatric practices with CSOC;
 - Focus on workforce development
 - Collaborating with medical schools, and other health professional programs;
 - Utilize predictive analysis/business intelligence;
 - **Practice**
 - Move away from “identified patient” model and serve whole families;
 - Provider training could be more standardized
 - Train system partners together;
 - Have DCP&P/CSOC integrated care plans;
 - Help families better navigate the system to reduce feeling of being overwhelmed
 - Have a single point of contact;
 - Broaden the idea of what families need, and increase “supports”;
 - Leverage the current pediatric learning collaborative for provider education, training and cross-system collaboration;
 - Better utilize parent and family leadership and recognize their critical role in system;
 - Understand the role of technology and make better use of it;
 - Screen for physical health issues within community providers;
 - Utilize a family based systems approach;
 - Do “family assessments” or SDOH screenings in primary care and connect to CSOC;
 - Move toward trauma- and attachment-responsive services;
 - Partnering more effectively with early childhood centers;
 - Engage community-based and family- groups to assist with navigation of services;
 - **Finance**
 - Rethink contracting and procurement practices
 - Multi-year contracting
 - Roll-over of contract funding into new FY;
 - Establish mechanisms to assess “need” vs. provider capacity;
 - Utilize federal funding streams (and optional Medicaid benefits), waivers/demonstrations to create new services;
 - Look at primary care reimbursement structures and how they influence addressing needs of children and families (e.g. SUD/SBIRT);

Convening Notes

- Use blended funding to increase services and supports;
- Explore the use of Social Impact Bonds;
- Standardize reimbursement and regulation of integrated care; and
- Ensure ideas from this task force are discussed in rate setting workgroup.

○ Other

- There are great things happening in pockets across the state – make sure to “spread” them across the state;
- Develop a community communications campaign to share what is available to families and how to access;

V. Debrief

- Ideas generated at this and the next two sessions 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.