Meeting Name	System of Care Design Group	Meeting Date	Tuesday, August 24, 2021
Meeting Purpose	Meeting #5	Meeting Time	1:00-2:30PM
	Materials: InCK SoC DG PPT	Meeting Information	Join Zoom Meeting https://zoom.us/j/8424051175?pwd=eDFWak1hSklHVXhkVERSSGZpTG5jdz09 Meeting ID: 842 405 1175 Passcode: cbc123

	Invited Attendees				
	Name	**Role - Organization/Agency**		**Name**	**Role - Clifford Beers**
✔	Giselle Carlotta-McDonald	Project Access-Executive Director	✔	Seth Poole	Director of Systems of Care
✔	Erica Garcia-Young	DSS	✔	Kitty Tyrol	Training Manager
✔	Amy Marracino	DMHAS - Adolescent/Young Adult Services	✔	Jennifer Richmond	VP of Population Health
✔	Cheryl Burack	Family Centered Services of CT		Xiomara Cuevas	Acting InCK Project Administrator
✔	Jacqueline Farrell	Family Centered Services of CT		Melanie Rossacci	Chief Business Development Officer
✔	Kellyann Day	New Reach		Luz Ramos-Ortega	CHO
	Victoria Hwang	New Reach		Taylor Smith	CHO
✔	Paul Kosowsky	Youth Continuum		JoAnne Wilcox	CHO
	Addys Maria Castillo	CityWide Youth Coalition	✔	Charles Dawkins	CB - Care Coordination Supervisor
✔	Smruti Vartak	Beacon Health Options -ASO		Lisa McKnight	Parent/Community Caregiver
	Kendra Carr	Beacon Health Options -ASO		Tim Marshall	DCF
✔	Brittany Williams	SNEPP			

MEETING AGENDA: Agenda Topic	Key Discussion Points / Decisions	Notes
Welcome	Introductions Agenda/Overview Purpose/Goal	● Seth greeted group members; names and affiliations entered in chat ● SOP Service Integration document was shared with the group; currently responding to CMMI feedback/questions
Meetings	Meeting Steps - Dates and Priority topics	● This meeting topic changed to focus on Terms & Conditions ● Two Future meetings resume topics
Recap		● NOFO ● CMS/CMMI expectations for Service Integration (SOP)
Discussion	Guiding Principles - from PCMH **Team Based Care & Practice Organization** *Example of principle to T&C:* ● *principle of embedding care coordination into medical practice is important →* ● *this could translate into T&C that says that for InCK providers in medical settings, there must be an established system level meeting/collaboration that happens at least quarterly between medical leadership and InCK care coordination leadership to ensure alignment of approach; there must be a codified process for individual case conferencing when InCK providers are delivering care management to an established patient of the medical practice and vice versa*	Discussion on system level alignment and Care Planning ● Cheryl asked about "embedding Care Coordination" in medical practices and CBOs working with multiple providers ● InCK is not strictly medical provider based; BH/MH and CBOs providing Care Coordination can be identified as InCK provider by patient attribution ● Giselle - PANH Care Coordination links to providers; Asks about payment process: to care coordinator or provider? ● Jen - this is in development with APM DG and will be informed by Medicaid Authority - TCM ● Paul - homeless youth/emerging adults may not be receiving any medical care; asks about Medical Home model and whether medical treatment (claims) is required for reimbursement of Care Coord. ● Erica - suggests that currently, provider/agency must have clinical staff to supervise Care Coord or hire Care Coords. We are using PCMH and WRAP as standards of care for the system. ● Jen - 2020 claims data reveals 35k pop and attributed providers as well as Unite Us utilization

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	Knowing & Managing Patients *Example of principle to T&C:* *Principle of family being listened to could translate into T&C whereby InCK providers must have written patient/family bills of rights or other formal protocols that outline how, when, and where InCK providers engage family members in care coordination* *Are there other terms and conditions to consider for example:* ● *Data collection* ● *Medication reconciliation* ● *Evidence-based clinical decision support* ● *Other activities*	● Brittany asks about using Trauma Informed Care by Care Coords - are they trained and aware of resources to make referrals?; clarified later - TI Approach to Care ● Erica - working on payment for TI training but currently Medicaid has no CPT code to direct bill for trauma screening ● Charles - CB Care Coords use 1-2 Trauma Assessments with Clinical follow up; flags categorized already if notifying Care Coord; meet with the Care Team through trauma lens
	Access, Care Management & Referrals *Example of how a guiding principle becomes a T&C:* ● *transportation and childcare barriers were important to address as it relates to access* *The T&C may include:* ● *requiring participating providers have written protocol on how to facilitate the broadest possible access to families and children facing transportation or childcare*	● Kitty asked if MI trained to Care Coords ● Charles confirmed that MI, Engagement, Crisis Planning Modules of WRAP are trained yearly with Quarterly refresher/boosters needed Jen - revisited 2020 claims data - beyond the PCP/OB pop, 7500 beneficiaries are not attributed to a provider Erica - watch and update Cheryl - kids with special health care needs; what about kids who have not seen a health care provider in last year? Most medical providers do not provide Care Coordination. Giselle - asks: 1. when does care coordination stop (end) - what is the requirement?

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	barriers: ● *for example, direct transportation delivered by provider, transportation vouchers, extended and/or weekend hours, and virtual care when necessary and desired by children and families* *Are there other terms and conditions to consider for example:* ● *Convenient access to INCK supports* ● *Information sharing among InCK providers* ● *Managing patient referrals to minimize cost, confusion and inappropriate care.* ● *How are care transitions managed?*	2. referrals: who in care coordination, where are we housing the data/information? platform? so others can see care coordination communications. what is reimbursement based on? time can be considerable investment to document. Seth - outcomes of referrals? where are they captured - best practices.
	Information Technology & Unite Us *Example of principle to T&C:* *Principle of accessible and user-friendly platform translates into T&C whereby all InCK provider must provide information to children and families (developed and provided by CT-InCK and Unite Us) on how to self-refer to services through Unite Us web platform* *Are there other terms and conditions to*	● Seth - contract signed with Unite Us ● Giselle - care coordination notes and communication ○ SOP, Unite Us capacity? now and future functionality ○ Care Coord on steroids! linkages, providers, follow-up rely on tech and comms ○ UU now - translates info, emails and texts parents ○ upcoming demo - new tools ● Paul - concerned about grants/documentation req'ts and linking one system of info/data with another ● Jen - Dr Sude suggests NOT asking providers "to do 1 more thing"; we have to streamline process; UU embedded in EPIC @ Yale with SSO

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	consider for example: ● *Use of Care Management Technology* ● *Consenting* ● *Other electronic documentation?* ● *Other ways to ensure referral success/how might we also require providers to follow-up on outcome of need (accepted, reviewed, recalled, rejected). Needs action, opened, closed,* ● *What would they consider an outcome measure beyond the process of a referral?*	● Giselle - ○ how much data from UniteUs is sent to CMS? Their current tool tracks outcome of referral, not need (to refer out/other providers). Tracking need - use other tools, NowPow for CMS grant and CLARA for clinical navigation. ○ how much documentation can be in UniteUs? EPIC has a history/chart and can log into Unite Us (211 in EPIC) to refer to resources ● KellyAnn - shared concern about limited “tracking” of referrals ○ asks what Unite Us can provide now/and needs to build out ○ Run reports? for each provider? ○ link to other platforms ○ trying to get hours needed to document for each client; spending too much time in computer platforms transferring info v. face time with clients providing serve ○ value and benefit ● Jen - contracted w Unite Us - fnx e-consent, Needs Assessment, SPoc ● If members are aware of other systems, enter in CHAT ● Cheryl - referrals, case notes? ● Jen - track referrals, NA, SILs, SIL3 - SPoC to share, individual unique records collected, case notes? duplication? or other preferred systems ● Cheryl - who reviews the records? ● Jen - CMS - Universal Needs Assessment and SIL determination cadence. T&C will id set of Questions and Care Plan - access to inform treatment? ● Paul - concerned about paper records, releases, and data protection ● Cheryl - NA results go to Beacon (ASO) to restratify. They are using

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		DPH and EPIC. ● Jen - unsure about paper linking to the provider system
	Performance Measurement & Quality Improvement *Example: Principle of completing needs conversations translates into T&C that outlines the timeframe by which needs assessments must be completed and data entered into system (Unite Us).* *Are there other terms and conditions to consider for example:* ● *Reporting frequency* ● *Community Task Force* ● *How might will the CHOs support continuous quality improvement (CQI) activities*	● Charles asks about incentives - for family? ● Seth - care coordinators/providers ● Jen - shares 80%completion of Needs Conversation req'd by CMS is too high; at best 30% is standard
	General Questions	● Seth - identified outreach to providers ● Cheryl - 62% of beneficiaries referred to her accept services; will look up # or % of Needs Assessment completion rate ○ CCMC auto sends referrals ○ no communication to families prior to referrals ● Charles - appropriate referrals; engaging providers means giving them something to do to keep them coming; engage family right away ● Cheryl - we will have a hard time engaging providers
Next Steps		● Add providers to next meeting(s)

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Walk-Ons…		•
Action Steps		•
Close	**Next Meeting:**	• Sep 13 @2:00PM v. zoom (Seth will set up zoom link and send)

Please see page 1 of the Draft SOP Service Integration for the list of CHOs and neighborhoods.

CHO NAME	NEIGHBORHOOD
Alice Corrigan	CHO (Westville)
Claudette Kidd	CHO (The Hill South)
JoAnne Wilcox	CHO (Beaver Hill/West Hills/West Rock)
Ken Okwuosa	CHO (Dwight/Edgewood/West River)
Leslie Brown	CHO (The Hill North/Downtown)
Luz Ramos-Ortega	CHO (Fair Haven)
TBD	CHO (FH Heights/Cove/Rt 80)
Taylor Smith	CHO (Newhallville/Dixwell)

New Action Item(s):	Person Responsible	Date Due
1. Outreach to potential members	Seth, JoAnne, Giselle, CHOs	4/30 - continued

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2. Schedule co-chair prep/fb meetings: Giselle, Seth, Kitty and CHOs	Kitty	5/4 - completed
3. Continue SOC DG write-up revisions	Kitty	5/6 - in progress
4. Prep Agendas, PPTs, materials for future meetings	Kitty	5/9 - completed
5. Finalize Meeting Notes and save to g-drive/email in MS docs to members	Kitty	4/30 - completed
6. Doodle poll for May meeting dates/times	Shayla	4/28 - completed
7. Determine May dates/times - Email Members; calendar invite, set up virtual link	Shayla	5/5 - completed

Old Action Item(s):	Person Responsible	Date Due
1. Identify dates/times for DG to schedule meetings/topics - elicit from Erica & Giselle	Kitty, Giselle, Seth	4/23 - complete
2. Continue revisions to SOC DG one-pager and PPT	Kitty	4/30 - in progress

Upcoming Deliverables/Status:	Person Responsible	Date Due
1. SOP draft presented to PC	Seth, Kitty, Giselle	Oct , 2021
2. SOP Service Integration draft to CMS	Jennifer	July 30, 2021 - done
3. FINAL SOP Service Integration to CMS	Jennifer	October 30, 2021

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SoC Design Group Member Contact List

Name	Agency/Organization	Core Child Service	EMAIL	PHONE
Giselle Carlotta-McDonald	Project Access New Haven Exec Director	Clinical Care (physical/behavioral)	Giselle.Carlotta-McDonald@ynhh.org	(203)688-4603
Erica Garcia-Young	DSS/Medicaid/CHIP	State/DSS Behavioral Health	erica.garcia@ct.gov	
Seth Poole	CB/InCK - Director, System of Care	Lead Org/InCK System of Care	spoole@cliffordbeers.org	
Kitty Tyrol	CB/InCK - Training Manager	Lead Org/InCK System of Care	KTyrol@cliffordbeers.org	
JoAnne Wilcox	CB/InCK - CHO	Lead Org/InCK System of Care	JWilcox@cliffordbeers.org	
Luz Ramos-Ortega	CB/InCK - CHO	Lead Org/InCK System of Care	LRamos@cliffordbeers.org	
Taylor Smith	CB/InCK - CHO	Lead Org/InCK System of Care	TSmith@cliffordbeers.org	
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Gerry Baird	CB/MCIS	EMPS	gbaird@cliffordbeers.org	
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Jacqueline Farrell	Family Centered Services-CT	Title V Agencies	jfarrell@familyct.org	
Kellyann Day	New Reach	Housing	Kday@newreach.org	
Victoria Hwang	New Reach	Housing	vhwang@newreach.org	
Paul Kosowsky	Youth Continuum	Housing	pkosowsky@youthcontinuum.org	
Addys Maria Castillo	CityWide Youth Coalition	Executive Director (Youth)	Addys@cwyc.org	
Smruti Vartek	Beacon Health Options	ASO	smruti.vartak@beaconhealthoptions.com	
Kendra Carr	Beacon Health Options	ASO	kendra.carr@beaconhealthoptions.com	
Tim Marshall	DCF	Child Welfare	tim.marshall@ct.gov	

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Lisa Willis	Grandparents Raising Grandchildren	Other Partners	ctbctrustees@gmail.com	
Lisa McKnight	Community Caregiver Representative	Parent/MOFJ	Lisamcknight45@yahoo.com	
Denise Duclos	NHPS Early Childhood	Early Childhood/Education	denise.duclos@new-haven.k12.ct.us	
Jennifer Richmond	CB/InCK, VP Pop Health, Project Director	Lead org	JRichmond@cliffordbeers.org	
Melanie Rossacci	Chief Business Development Officer	Lead Org	MRossacci@cliffordbeers.org	