InCK - DESIGN GROUP - System of Care **Meeting Agenda and Action Items** **2021**

Meeting Name	System of Care Design Group	Meeting Date	Monday, August 2, 2021
Meeting Purpose	Meeting #4	Meeting Time	10:30-12:00pm
	Materials: InCK SoC DG PPT	Meeting Information	JOIN WEBEX MEETING https://cliffordbeers.webex.com/cliffordbeers/j.php?MTID=m0a00104b1220f125c182e1dc94ec525b Meeting number (access code): 132 177 1891 Meeting password: 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

- Jennifer Gagnon - Beacon Health Options, Data Analyst

MEETING AGENDA: Agenda Topic	Key Discussion Points / Decisions	Notes

- Meredith Damboise

Welcome	Agenda/Overview - Discussion on SOP SI	
Meetings	Meeting Steps - Dates and Priority topics	● Today's meeting followed by next scheduled meeting Aug 24 ● Two more meetings needed in September
Recap	Giselle - SLIDE 6 - SoC Integrated Care Coordination SLIDE 7 - SI Goals	● Integrated Care Coordination ○ across service systems, providers & core child services ○ intensive for children at risk of out of home placement ● Service Integration Goals ○ single point of contact/coordination ○ provide services at home/in community
Timeline	Seth-SLIDE 8 - SOP Service Integration	Timeline: What we know and where we are headed ● Fall 2021 ○ InCK Providers Enrollment - CHO outreach ○ Claims Data Review gives us sense of SILs and providers ● SOP - submitted to CMS, awaiting Feedback from CMS and community; asking this group to review SOP ● Jan 2022 ○ Referral Process - Stratification, Provider Attribution, Needs Conversation explained "assessment" ○ ICC SIL2-3
SILs	Seth - SLIDE 9 - Service Integration Level	● SIL1 - attributed to InCK provider ● SIL 2 - 1+ service type and functional symptom or service type ● SIL 3 - key difference is risk to be placed out of home

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InCK providers & Core Child Services	Giselle-SLIDE 10 - ICC - for SILs 2-3 SLIDE 11 - Care Planning Teams (SILs 2-3)	• Core Child Services - CMS defines across service systems for children • Who or what is an InCK provider
Discussion	Seth - SLIDE 12 - Centering Family in Care Coordination	***Ask: What is your sense of family-centered care and communication?*** Cheryl - we've talked about this; family is listened to in terms of needs, priorities, goals. CC is designed to help family meet those goals and have needs met. Kellyann - Health Records w Dr/Hospital; e.g. MyChart at Yale or Hartford Health. Tests, appts, manage our health. Why can't we have smtg like that for Behavioral Health and SDOH - platform centers on the person, not the funding source of wWho or what is an InCK provider who is paying for it. Often given metrics from funder to maneuver resources. Platform focus on child/family - all have access to review and give providers same thing. Missing from our work. Meetings and emails not enough. Smruti - Unite Us to create the platform. ICC and providers will have access. Data Hub for all things. Support system, finances, school, medical. Focused on person AND program requirements. CMS wants to collect. Another diagram for technology/communication - Unite Us. Capacity to send out reminders and texts, messages, emails. Supports should include strengths. Giselle - quantity of patients to ICC - challenge of quality of having enough time to listen, address needs.

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		Seth - many families receiving family-centered care, PCMH/PCMH+, Behavioral Care Providers; how do we level up? for family? Kellyann - tablets with built in internet/service to have tool to access their care. Seth - Kiosks; MOMs in Stop & Shop. Multi-modal. QR codes. Gardens - recipe cards. Technology to conduct Needs Convo. ***Asks: essential to have reimbursement tied to Needs Convo? Incentivizing ppl to participate in initial conversation? Stipends.*** Smruti - for SIL3 - two convos in year. long term project. for each beneficiary or for SIL3. Smaller amount $ one time. Substantial amount. Seth - 30k ppl. Limited number of care coordination meets criteria. Initial point of engagement? Waiting to see which providers will be "home" to ICCs. What are the types of approaches to engage families? Smruti - incentives do make a big difference. Pick one winner/week - coupons or discounts. Pay for performance initiative for providers; also using CHOs - incentive plan to finish #, bonus. Claims data to start with for initial SIL. Needs Conversation affirms or validates SIL. Seth - Youth Connect; city of NH with NHPS; engaging or re-engaging youth also tiered. We seek alignment with other initiatives and best practices. Raffle? submit paperwork to the state? Families in need.

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		Smruti - Care Coordination in PCMH - medical home concept Cheryl - serve children birth to 21; special health care need if they have conditional lasted/or will last 12 months or more - medical, dental or behavioral. Most referrals in last year were autism, noticeably higher as well as asthma. Seth - anecdotal suggestions of folx moving into CT for healthcare. Caseload #s? by Age groups? Cheryl - outreach and home visitation; access w/o worry about transportation or child care. Seth - NCQA workshops, last week spec geared towards receiving medical care in home; "Doc Hollywood" approach/Dr. Leslie Sude. How capable are we as community to support this approach? Wellness visits, postpartum, infants/toddlers. Erica - asks Cheryl to expand on outreach and family engagement barriers: Cheryl - not everyone wants us in home, time is the biggest barrier - see more ppl if they come to you than going out; time, staff, resources, capacity as well as size of territory, travel, cars, gas. Another approach is to be embedded into a medical practice to see them as they come in for visits. Seth - limitations in Care Coord model; expanding in NH. Care Planning Teams: what does it look like centering a family? Kellyann - CPTs come together to coordinate and then present to family.

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		Housing; in such crisis, team giving clear and well-thought out options to avoid frustration for families. Family involved in decisions with clear options. Homelessness - 25 yrs shelter; now diff housing options - exit plans, affordable housing, transition, etc. Prevention! *Reaching Home campaign Steering committee* (22 years) - facing evictions tsunami coming! Which ones are likely to end up in homeless system if not "unstably housed." (Melville is primary funder) Funding used for most likely to become homeless. Often the proverbial "straw". How do we design something to prevent. Predictive characteristics? What is cross-collaboration with other systems. Much harder to find housing than to stabilize in housing. EGY - homelessness indicates a SIL3? Kellyann - yes; can bring language to it as "imminent risk" or "acute" crisis Kitty - invisibility of child/family if unhoused during acuity of crisis. Kellyann - McKinney-Vento def is broader including being doubled-up; HUD - in past 7 days, uninhabitable place or outside? Kellyann - access to youth for shelter beds is limited <18 yo and youth parents fear identification as target for DCF removal of children or others are most at risk. Not enough resources for youth; developmentally, often prefer couch-surf. City is deciding on funding to go towards housing. Connect offline to address. Seth - ESSER $ for spending. Cannot spend 15%> on infrastructure. Other spaces. EGY - familiar with CHESS program?

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		Kellyann - Yes, YC is provider of CHESS - first referral last week!
Next Steps	✓Terms and conditions for InCK provider eligibility ✓InCK provider outreach and engagement ✓Family and Caregiver outreach and engagement ✓Information and Promotional Materials	Next conversation about InCK provider eligibility T&C Smruti - is it possible to get providers input; to attend this meeting? Planning is our work, but their input is needed as to how to carry the work. Seth - yes, to engage one of the medical providers, PCMH+.
Walk-Ons…		● CHO list and neighborhood assignments (see below)
Action Steps		Please read the SOP and provide us with feedback-comments, questions, suggestions. ● Kellyann requested list of SICs (CHOs)
Close	**Next Meeting:**	● Aug 24 @1:00PM v. zoom

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

CHO NAME	NEIGHBORHOOD
Alice Corrigan	CHO (Westville)

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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
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

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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
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	
Charles Dawkins	CB/CST	Care Coordination	cdawkins@cliffordbeers.org	
Gerry Baird	CB/MCIS	EMPS	gbaird@cliffordbeers.org	
Amy Marracino	DMHAS	Adolescent/Young Adult Services	amy.marracino@ct.gov	
Cheryl Burack	Family Centered Services-CT	Title V Agencies	cburack@familyct.org	
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	

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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	
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	