DATA TEST/HIGH PERFORMANCE

WebEx – See Invite
By Phone: 312-535-8110, Access # 1774928747#

January 22, 2021 at 9:30am – 2pm

Minutes

I. Attendance/Roll Call

Roll call completed. George Kaduthodil introduced himself as the new member of Clinical Services, formerly known as Placement Resources. Sherice Ewing, introduced herself as the new Monitoring Field Manager for Downstate. Luis Rodriguez also introduced himself as the Administrative Assistant to the Deputy Director for Monitoring.

II. Approve previous meeting minutes

Minutes were approved as written

III. YouthCare – Anika Todd/ Lamont Boswell

Anika provided an update that they are working hard to get the training portal out and are attempting to identify some dates on portal training. Continuity of care period is ending next month, and YouthCare is working with providers to ensure that they are in network, especially the specialty providers ensuring that credentials are in place, etc. Lamont and his team have been working on BMN youth and when youth are admitted into the hospital for behavior reasons, to assign YouthCare Coordinators to be part of the initial hospital staffing throughout the discharge. Noted this is a daily list that gets sent to Lamont's team.

Lamont noted that they went Live last year, and they have had some experience with youth in care and former youth in care. They meet on a regular basis with HFS and DCFS. This is something that his transformational and they recognize that it does not happen overnight.

Best way to obtain the newly assigned YouthCare, when there is a change in YouthCare is to get in touch with Lamont or Anika. However, if the former Care is still employed with YouthCare, they have the ability to provide the newly assigned Care Coordinator contact information.

Anika noted that any inquiries/issues/concerns should be directed to her and Lamont. She is not able to answer contracting or billing questions directly however, she is able to get you to the right place.

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IV. Phase II- HMP/HMR/HFK Project – Angela Hassell

Monitoring and Clinical embarked upon a Phase II project, in which their focus is on youth who are targeted to step down to Home of Parent, Home of Relative, or Home of Fictive Kin. Placement Resource should already be identified for that population and the hope is to provide additional support to the treatment team, as they work on transitioning those youth. The expectation is that the assigned Monitor, Clinical Specialist, and Care Coordinator would all be part of the staffing to provide additional support, when and where necessary. The hope is to work together to develop a solid plan for our youth and family, identify any barriers, and work together to look at ways to rectify those barriers.

Monitoring has a process that might be slightly different from TRPMI. Monitoring has a staffing each Monday afternoon to provide update on this population and discuss what needs to be done to support move the youth's transition forward.

Some of the challenges is the need to expand the IPS services as there is lengthy waiting list for some, in certain areas. Also youth that are targeted to step down out of state, where ICPC is involved in the transition. There is an expectation that an out of state provider that would provide additional support must be identified, in order for the ICPC referral to be approved.

Currently there is a total of 58 kids that have been identified within that population. We started off in September with a total of 43 kids however, some had changes along the way such as change in living arrangement.

Monitoring has partnered up with Operation and requested that they prioritize youth within this population. Noted there does not seem to be a sense of urgency, all around to transition these youth. The hope is that the process will create some sense of urgency for the team to work diligently to transition youth sooner than later.

It was inquired if it was more lack of urgency or lack of capacity that is slowing with process down. It was clarified that it was more of lack of urgency than capacity. Noted, if a youth is clinically ready to go then there should be a sense of urgency to transition that youth. It is recognized that there may be some challenges along the way, such as inaccessibility to after-care resources due to the pandemic and long waiting lists.

Ashley shared that there is a Provider 2.0 database being developed by DoIt. Neil added that the purpose is to modernize the way that provider information and payment occurs. Spider will be integrated to allow for a master database where services/support can be identified geographically.

The team had a brief discussion regarding Spider being a real time database system and some of the challenges it presents now. It was also discussed that better data is needed in order for providers who are willing to expand their services, to get an understanding of what is needed and where it is needed. It was inquired if there is any work around utilizing integrated health homes, and there has not been any information shared around that topic. Mark explained that integrated health home is for 0 – 21yrs old that uses public insurance for any health services such as mental health or physical health; would be part of integrated health home if they meet certain criteria. They will either fall in the wrap around services or lower tier. There is also integrated health homes for adult as well. Integrated health homes has not been initiated yet, however discussion is being had at some of the CWAC committee.

Noted that Monitoring is looking at all youth on Phase II, especially those who have been in their residential treatment program for more than 18 months.

V. Family First

a. Update – Ashley Deckert/Keith Polan

5 additional agencies have been identified to be part of the soft roll out. The team is developing communication to advise those agencies. By March there would be a mixture of large/small agencies serving big/small population in each region participating in the soft roll out. 2 agencies in Northern, 2 in southern, and 2 in Central, and 2 in Cook. Court portion of the roll out should be launched in March as well. Any youth coming into any of the agencies would go through the 30-day process and the assessment would be sent to our legal team. OITS is aligning the March 1st rollout with some very key critical SACWIS changes to test as well, such as 906 codes.

Last field primer is next Thursday, and that would bring the total to 6 congregate care primers. There would be 3 full day Family First training to include information on prevention and QRTP starting in April. The team has also been in communication and close contact with judges across the state. Training was provided to judges, jail attorneys, public defenders, etc. the training was recorder and will be on the Illinois court website and can be accessible at any time for a refresher. There are 3 more court

training coming up as well. Work is being put forth to convene a meeting with a group of judges (8) to review the independent assessment and provide feedback, if they feel the information provided is enough for them to make a decision. Keith noted that more education needs to be pushed on the Case worker side.

Ashley shared her idea of creating a flow chart, which would allow for people to see where they are or if there is failure, where exactly if occurred. Angela shared her idea on developing an Advisory group that would include members of the agencies participating in the soft rollout to catch some of the lessons learn and address barriers. Angela also shared that another idea could be to create a mailbox where issues/ concerns/ questions can be sent.

Noted there is a required Human Trafficking training. However, because there is a need to establish an ongoing support for direct staff and there is a call for proposal for anyone that can provide that training.

b. Data Points Discussion – Angela Hassell/Mitchell Sandy

Given Family First and QRTP, we want to be thinking about what changes that need to be made with how Monitoring does its work, and do we need to change the things that we are measuring? With this as the context, there is thought that we will want to expand changes to monitoring, and measurement changes. Thinks that new measures should follow new monitoring. There is a technology piece as well. We want to think sequentially.

- We are best able to address the data around the QRTP piece.
- Angela offered the opportunity to have this discussion with the Statewide monitoring team on 2/25/21.
    - Suggest that we form a smaller workgroup with all of the key people to support the goal to figure out what changes need to be made to monitoring to support Family First. (This group, monitors, provider representation, TRPMI)
    - The workgroup's obligation to report back to the larger group. Same as it was done with the Length of Stay committee.
    - Knowing that it is hard to do the work. Once we figure out the changes to monitoring.
        - The group then develops into a new workgroup, then talk about the changes to the measures. What does monitoring want us to measure that can help them do their work?
        - The small workgroup would have more frequent work meeting sessions
            - Maybe twice a month

Angela extended an invitation to Northwestern team to have this discussion at the Statewide Monitoring All Staff meeting in February. Jennifer recommends having a breakout session during the All Staff.

- Ashley noted that some of how we will do monitoring in the future will very much be tied to BH.
- Additionally, as it relates to QRTP – it is fairly straightforward.

Neil noted that we are waiting for more guidance on BH, and he is thinking about how monitoring gets done.

Next Steps:

- Added to the Provider Community Agenda
- Determine a representative to participate in a smaller group
- Also engage Allen Yang around technology that may now be possible

c. Trauma Informed Care Practice Tools

There was a discussion around assessing agencies around Trauma Informed. Neil suggested to determine what did we tell the feds and what are our goals? This would allow us to determine what we are trying to measure. Ashley confirmed that the feds left it broad, and we defined trauma informed care for the system. However best practice and our standards are little higher. Leading to us developing our tools, assessing the quality of the agency models. Noting that there are some agencies that do well in providing a trauma informed agency/service and some need to be enhanced more. Therefore, it is foreseen that we need to be able to develop a tool that assess – meets, needs, exceeds. Therefore over the span of a year (time) we are working with providers to get them to place whereby they are exceeding. Noting that although there is a low threshold to determine whether an agency is Trauma informed, there is still expectations that the agency would perform at a higher level.

Linda also noted that many agencies have their own fidelity model and looking at agency's own assessment in this process. Neil noted a conversation back in December and shared three elements that were brainstormed and inquired if there are any changes to them – 1. Milieu based component, 2. Included training, and 3. demonstrate fidelity.

Next Steps:

- Invite Cassie to engage us and providing some insight with the guiding principles, sort through potential tools to determine what would make sense to us. Can

d. PBC – Jennifer Prior

We desire to revamp PBC and tie more closely to Family First and monitoring. There may be others that we want to engage to address the nuances to the metrics. There is a need to identify what sort of changes is

needed to meet the Family First requirements in Monitoring, how to make those changes, and to what extent to we change things that are being measured. Alan noted that there may be a need to bring Allan Yang to the table to determine what can be done now technologically that weren't able to do then. Alan also noted that there are two sides – what do we have and what would we want to bring on board? There may be other options.

1. Does what we have still make sense?
2. Are there things we could do to enhance them to make more sense?
3. Are there things that we could add?
4. How does this information link back to monitoring?

There is a thought that Statewide Monitoring All Staff could be utilized as an opportunity to have the PBC discussion with the entire monitoring team.

Neil's thoughts are to:

1. Form the 1st small group that would figure out what changes needs to occur in Monitoring
2. Form a 2nd small group to discuss what changes to the measure needs to change

There was a brief discussion around whether this should take place now regardless of potential changes in monitoring, related to BH. Also, who should be brought to the table and if, there really is a need to move forward with the idea. Noted there is a need to have big and large agencies at the table to allow for different experience.

The recommendation would potentially be shared at the next Providers' meeting and allow opportunity for those who would like to be considered to join the group. There may also be a need to bring in some monitors to the table.

With Dennis retiring, he recommended Mary Ann Berg to join the work group and she as agreed to be part of the team.

Next Meeting: March 5, 2021 at 9:30am (WebEx)