



INTEGRATING FAMILY SERVICES

Stakeholders Meeting

Meeting Minutes

03.07.2016

Attendees: Adam Sancic, Alicia Hanrahan, Alix Gibson, Amy Danielson, Andrea Grimm, Angela Walters, Anita Thomason, Ann Dillenbeck, Aula Dewitt, Barb Cimaglio, Barb Joyal, Bart Mair, Becky Raymond, Belinda Bessette, Beth Truzansky, Bethany Pompbar, Betsy Cain, Bill Snyder, Bonnie Jamieson, Breena Holmes, Carol Boucher, Carol Lang-Godin, Carol Maloney, Carolyn Hatin, Charlie Biss, Cheryl Huntley, Cheryl Bilodeau, Chloe Leary, Christine Johnson, Christine Reid, Chuck Myers, Cindy Tabor, Claire Kendall, Craig Comstock, Cynthia Greene, Dana Anderson, Daniel Hall, Danielle Howes, David Bogdan, Denise Main, Derek Kouwenhoven, Diane Bugbee, Donna Bailey, Doug Norford, Dru Roessle, Eric Bach, Erin Oalican, Gerda Lenselink, Greg Stefanski, Heather Case, Heather McLain, Jane Helmstetter, Jenni Campbell, Jo Bania, John Allen, Julie Cadwallader-Staub, Julie Pagliccia, Kathy Holsopple, Keith Grier, Kendra Perland, Kim Friedman, Kreig Pinkham, Kristin Prior, Laura Kass, Laurel Omland, Laurin Kasehagen, Lily Sojourner, Linda James, Lorna Corbett, Lynn Boyle, Marc Adams, Mark Johnson, Matt Wolf, Matthew MacNeil, Michael Curtis, Nancy Simons, Natalie Whitfield, Nicole Mosher, Reeva Murphy, Robyn Daley, Roy Gerstenberger, Russell Bradbury-Carlin, Sadie Fischesser, Samantha Thomas, Scott Johnson, Shane Oakes, Shawn Skaflestad, Susan Bartlett, Susan Coburn, Terri Edgerton, Tiffani Hubbard, Tracey Mongeon, Trevor Hanbridge, Valerie LeGrand, William McMains & William Shakespeare.

AGENDA ITEMS	DISCUSSION POINTS
	MORNING
❖ What is working well with IFS?	<ul style="list-style-type: none"> ○ Two very separate systems of care – creating one door regardless of diagnosis for services, build a plan based on needs not funding. IFS created this “single door approach”. (HCRS Windsor County) ○ More families with children who need developmental services who are getting a broader array of services with the IFS model (Family Perspective, Vermont Federation for Families). ○ Fee for Service model = tracking hours of care per month. Case rate = counting goals achieved and kids served because of IFS (Pilot, NCSS).
❖ What are the lessons learned with IFS?	<ul style="list-style-type: none"> ○ “The space between us”. Learning how we work together, include each other and respect each other has made a big difference. ○ It’s not easy, it’s not fast and it’s not simple. ○ IFS has brought sometimes usual and sometimes unusual partners together which results in more flexible thinking.
❖ Questions	<ol style="list-style-type: none"> 1. How is family voice is embedded in IFS? <ul style="list-style-type: none"> ○ A family advisory council has been formed in Addison, and a position has been created (“Parent Support Provider”) to meet monthly with parents to provide feedback and provide input to decision making. 2. What will happen past June, after the IFS workgroups are done meeting?

AGENDA ITEMS	DISCUSSION POINTS
	<ul style="list-style-type: none"> ○ This is a continuous improvement model so there will likely be a new set of initiatives and priorities for work groups to tackle starting this summer. <p>3. How is Child Adolescent Needs and Strengths (CANS) embedded in your region?</p> <ul style="list-style-type: none"> ○ NCSS has been using the CANS model, as more of a system of care tool, to learn if children, youth and families are better off with the current set of services that has been possible because of IFS.
<p>❖ Panel: Members from each IFS region</p> <p>Q&A</p>	<p>1. Why do you believe in IFS?</p> <ul style="list-style-type: none"> ○ We spend time together, we work together, we believe in each other. ○ We are doing better work by working with families and paying attention to how we work together. ○ IFS has been a way to challenge the system. ○ IFS has provided an opportunity to break down silos and rebuild something that we wish we always had. ○ We are able to shift the relationship with the family’s current workers to match the needs of the family. ○ We’ve become more skilled and more family-friendly. <p>2. How have you connected, integrated and/or coordinated with the LIT’s and BP collaborative structures?</p> <ul style="list-style-type: none"> ○ Our IFS group is the umbrella, with the IFS council being under that and the IFS steering committee. The LIT, E.C. and Family Advisory group are all subsections of this umbrella and the BP coordinator is on the steering committee. (Addison) ○ We have the LIT, YIT and Parent Advisory but not a strong connection with the BP. We are in the early stages of collaborative structures but have been partnering well together internally for years. We are trying to turn this into more of a systemic partnership (F/GI). <p>3. Challenges with IFS?</p> <ul style="list-style-type: none"> ○ We have to be able to reinvest savings. ○ It has been easier to break down barriers at the local level than the state level. ○ It is hard to manage IFS with a global budget. ○ Competing for funds and turf among agencies = challenge in getting folks together in the same room to learn how leverage the resources to the benefit of all ○ Letting go of the control over the waiver system, believe it will be ok with IFS funding ○ How to “language” IFS in our community ○ The funding flexibility in IFS is great, but the CAP is still there which proves to be a difficult balance.
<p>❖ Note Card Questions</p>	<p>1. Leadership & Governance</p> <ul style="list-style-type: none"> ○ What is the thinking rationale around fiscal agent and the role of governance with revenue and expense decisions? ○ Talk about how local governance has changed how you do business and how has it improved “getting things done”? ○ What barriers, if any, existed when trying to create a governance community group? Some community partners prefer to offer services independent of a larger collective group. ○ How do you have balance the number of potential partners with the need to have an effective and manageable team? ○ What happens when someone refuses to come to the table? ○ How have governance groups been formed and who sits at the table and why?

AGENDA ITEMS	DISCUSSION POINTS
	<p>2. Finance & Payment Reform</p> <ul style="list-style-type: none"> ○ Has finance flexibility allowed you to mitigate level funding? ○ Have IFS efficiencies allowed you to raise staff salaries? If so, by how much? If not, is that an improvement that IFS will allow you to make? ○ How have the services identified for families been funded when they may not be currently available or “created” in the system? ○ In the event a particular system becomes responsible for providing this service vs. other community partners, are there additional funds provided on top of or in addition to what was budgeted for? ○ What is in the bundle and who decides? (CYF MH FFS, CYF Waiver, DS Waiver, NFI carve-out, VCRHYP, DCF (?), ADAP) ○ How will daily rate, case rate and fee for service payment models fit together under IFS? <p>3. Accountability & Oversight</p> <ul style="list-style-type: none"> ○ What does quality improvement look like? ○ How are you measuring IFS program performance? ○ What community indicators of well-being have changed? ○ Have IFS master grants reduced reporting and data collection requirements? ○ Is community level data as readily available as needed? ○ Is program performance data reported/shared publically? <p>4. Big Picture Integration</p> <ul style="list-style-type: none"> ○ What are state level agencies doing to integrate? ○ How has IFS engaged (or been engaged by) the Unified Community Collaborative (UCC) in your area/region? ○ In what ways have state silos been broken down and stream lined as a result of IFS? ○ Please comment on how much “melding” of state policies, procedures and administrative practices that have resulted from IFS? ○ IFS is an AHS initiative. Many family services are actually provided through schools. How will IFS bring AOE into the integration model? ○ What communication and/or connections have occurred with organizations outside of AHS? ○ Specifically, what is the coordination with healthcare initiatives? (especially since doctor’s offices are hiring social workers). ○ How will implementing IFS effect how ACT264 is changed in the community? ○ How does this detail/challenge the ACT264 process as we move forward in different regions particularly at each level? How does equity and DS waiver steps fit in? ○ How does one agency in a county know how to integrate IFS with other agencies in that county? ○ How do Promise Communities fit into IFS? <p>5. Designated Agencies</p> <ul style="list-style-type: none"> ○ How does IFS fit/blend with DA process requirements/responsibilities and how does governance fit into this blend? ○ IFS appears to be leading all families to the DA’s. If a family wanted “choice” of provider, will that be an option? Specifically, individuals with ID/DD choosing an SSA as their provider. ○ How have you expressly addressed change in culture as well as practice (or not)? ○ As IFS determines the assessments what mechanism will be used to share the scores and not ask families to double complete forms?

AGENDA ITEMS	DISCUSSION POINTS
	<ul style="list-style-type: none"> ○ How can we use the collective impact model to move IFS forward? ○ If the SF Protective Factors Framework were fully in place, what would it look like and what would be different? ○ What is the most beneficial/useful professional development for staff? ○ Are there administrative burdens (i.e., paperwork) that have been lifted? Are there administrative burdens that are still left? ○ I'd like to hear "active" regions speak to the dialogue between partners (community partners) and families who may share a common goal (helping children, youth and families receive what they need) but may have a different vision as to how that can/should be achieved. And/or have different philosophies toward that end.
	AFTERNOON
<p>❖ Small Group Discussions</p>	<p>1. Areas that need work/things to focus on/change</p> <ul style="list-style-type: none"> ○ Service delivery ○ Operationalize system ○ Family engagement/voice ○ Accountability and shared accountability – oversight – whole population and program performance ○ Data ○ Money ○ Collaboration <ul style="list-style-type: none"> * Consistent school participation * Bringing education and health care into IFS more consistently and systematically * Integrating existing initiatives ○ Growth Areas <ul style="list-style-type: none"> * Identifying the 1st step or framework internally and at the community level * Learning how to integrate all philosophical approaches into a cohesive team while still allowing for individuality and strategies to pull in other providers (probation/parole and court diversion) * Continue defining/clarifying what is IFS, what is the baseline requirement and what is flexible * Understanding of IFS for direct service staff ○ State team <ul style="list-style-type: none"> * Performance measures on integrating grants * Integrating at a state level * Performance measures on reporting * Performance measures on integrating performance measures * Keep breaking down silos and territoriality (i.e. DCF is not solely responsible for all decisions around families) * Act like one agency statewide and locally ○ Lessons learned/guidance on development of governance ○ Reduce documenting and streamline services ○ Align outcomes across AHS

AGENDA ITEMS	DISCUSSION POINTS
	<ul style="list-style-type: none"> ○ Time management of IFS commitments ○ In 2 pilot regions they seem to be working well on issues regarding money, time and resources ○ Clearer organizational chart for different levels of IFS for regions ○ Work group concept, especially statewide ○ How can IFS help bend the curve for agency staff turnover? ○ Growth across departments – no alignment with policies and practices ○ Get IFS message to direct service level support supervisors/managers in collaboration ○ Integrating of CIS into IFS for 0-3 aged kids – clarification of EIR role of DS <p>2. What to hold onto/build on?</p> <ul style="list-style-type: none"> ○ Payment Reform <ul style="list-style-type: none"> * MH bundle * Flexibility in funding * Get out of FFS – move to case rate for all * Moving from case rate to blended rates, with as much flexibility as possible and incentives to take this on ○ Prevention <ul style="list-style-type: none"> * Including a focus of prevention and promotion in IFS work * Savings reinvested back into communities (focus on prevention) * Focus on building systems that improve population health at local and state level through payment and practice reform ○ Accountability & Oversight <ul style="list-style-type: none"> * Continue data and shared accountability * Ability to be innovative – increased flexibility ○ HR & Organizational Culture <ul style="list-style-type: none"> * Agencies developing an understanding between each other * Increased staff confidence created by community relationships and a more streamlined approach * Speed of IFS is in the LIT process * Willing to sail a ship we are building * Collaborative efforts * Getting everyone to the table to problem solve regarding family/community needs ○ Service Delivery <ul style="list-style-type: none"> * Flexibility that each region has differing needs * Keep multigenerational approach to treating families holistically - not just one kid * Teaming * Multi-disciplinary approach in teaming * Ability to shift staffing patterns to address needs to community * Getting rid of silos

AGENDA ITEMS	DISCUSSION POINTS
	<ul style="list-style-type: none"> * Early initial integration of DS/MH at local level has been a huge strength * Case managers, DCF workers can be more flexible * Community establishes their own priorities within known parameters ○ Leadership & Governance <ul style="list-style-type: none"> * Forming of creative partnerships that were not thought of previously * Continue horizontal and vertical integration across sectors and between state and local entities * Bottom up design * Strong relationships at local level including medical, human services and schools ○ Communication <ul style="list-style-type: none"> * Need more regular and consistent messaging about IFS to get to all AHS levels * Need more messaging on logistics/details beyond philosophical construct * Better IFS definition to translate through state ○ Family <ul style="list-style-type: none"> * Case manager for family as a whole * Family centered approach – ability to understand the needs of a family without concern for specific program eligibility * Family focused perspective * Focus on families * Stay centered on the perspective of the family’s experience – create systems and teams from this perspective * Philosophy of focusing on family’s needs first * Focusing family at the center and figuring out things around them <p>3. Youth & Family Engagement</p> <ul style="list-style-type: none"> ○ <i>Top priorities for 2016-2017 (from 1st round of discussions)</i> <ul style="list-style-type: none"> * Need money to support family advisory and peer navigation * Lack of engagement from clients – need education on IFS for families * Youth is missing – IFS is focused on family and early childhood, where are bundled services for adolescents? ○ <i>Specific recommendations (from 2nd round of discussions)</i> <ul style="list-style-type: none"> * Create funded positions to engage family and youth voice * Engage parents and youth who have experience with the system(s) but have gained distance from it and had space to reflect * Gather feedback from families and youth on an on-going basis with documentation/feedback loop to IFS team to address barriers * Involve youth and family input in treatment/case planning * Incentivize youth and family participation in meetings * True commitment to family voice and involvement, aka money * IFS model should include a “paid” peer family/parent support provider as appropriate per region <p>4. Service Delivery</p>

AGENDA ITEMS	DISCUSSION POINTS
	<ul style="list-style-type: none"> ○ <i>Top Priorities for 2016-2017 (from 1st round of discussions)</i> <ul style="list-style-type: none"> * How to address the uninsured and underinsured? * CAP limits? * Expand portfolio to third party? * Continue to form system to improve coordination * Lack of support for administration/coordination * Focus on prevention/promotion using strengthening family’s framework – moving from theory to practice – operationalize in communities * Cant prioritize children over parents or vice versa; family focus ○ <i>Specific recommendations (from 2nd round of discussions)</i> <ul style="list-style-type: none"> * Recommend more flexibility in paying for services for entire family – in single payer system * Limits (cap) should be based on needs of family rather than set dollar limits * Seek out community organizations to see what they can contribute – leverage resources * Point person/team to coordinate services * Who is involved in IFS? How does the collaboration work? * Where are the gaps? What services are within IFS and which are not? * Can we figure out ways to fund an administrator to facilitate/organize non-direct service components * Is there a way to embed a position on the governance teams across the state – should it be a state or local rep? * Is there a way to look at all of the local expectations and trade off effective for non-effective or cumbersome reporting requirements? * Need more “behind the scenes” support to input/analyze data from the CANS (i.e. CANS admin team) to better use staff’s time * Practice based evidence – collect data to build evidence of effectiveness * Operationalize the five protection factors * Crosswalk between protective factors and available services in each region – identify the gaps * Families need peer support and skill building opportunities * Need to work in partnership with families to identify their own goals * Have services wrap around child and family as opposed to family going to services * Compile a list of concrete programs currently offered that address five protective factors * Fill gaps * Adjusting language and mindset toward family “unit” * Look back at policies and guidelines * Look at screening process for assessment * Offer training and supervision around questioning techniques to getting at the problem with minimal probing <ul style="list-style-type: none"> ▪ Looking at whole situation not just the one problem on the table (i.e. resource and referral)

AGENDA ITEMS	DISCUSSION POINTS
	<ul style="list-style-type: none"> ▪ Laying out at the start resources available and the eligibility requirements for specific programs * How to look at opportunities for “cross-funding” <ul style="list-style-type: none"> ▪ Servicing parent but notice similar need in child but can’t use same funding ▪ Crisis management but not funding for multiple facilitators for one family * Collaboration between school staff (student) and family services (parent) <ul style="list-style-type: none"> ▪ Case lead and service workers underneath for ground work ▪ Education across services on all the resources available so not doing double work <p>5. Financing & Payment Reform</p> <ul style="list-style-type: none"> ○ <i>Top priorities for 2016-2017 (from 1st round of discussions)</i> <ul style="list-style-type: none"> * Improve how to change federal rules or use state dollars to free up federal dollars for their very specific purposes * Need flexibility to allow for hybrid models of financing * Growth need to work out financing issues – grantee vs fiscal agent – including SSA’s * Build smaller bundles and then bundle those smaller bundles * Need to address time challenges to avoid leaving folks in meetings and not having time to do and coach staff, etc. * Keep learning at every level how to manage a “global budget” and balancing capacity to meet current need with investments in prevention and decision-making * How to balance who gets what for funding each region ○ <i>Specific recommendations (from 2nd round of discussions)</i> <ul style="list-style-type: none"> * Go from fee for service to per member per month (bundle creation) * Micro bundles – managed at local provider * Bundling micro bundles – governance * All payer model - healthcare integration <ul style="list-style-type: none"> ▪ Increase representation at healthcare conversations ▪ Increase money stability of local human services agencies (i.e., DA’s, PCC’s, SSA’s, Subcontractors) ▪ Convince healthcare players (GMCB, Legislator, etc.) of the value/importance of children and family services ▪ Increase our expertise on payment reform ▪ Develop incremental steps <p>6. Data and Technology</p> <ul style="list-style-type: none"> ○ <i>Top priorities for 2016-2017 (from 1st round of discussions)</i> <ul style="list-style-type: none"> * Grant reporting requirements – general and challenging with blending * Data requirements need to be streamlined and relevant * Need community data available on population outcomes (like AHS community profiles) to make progress on outcomes together * Reporting – very difficult within IFS ○ <i>Specific recommendations (from 2nd round of discussions)</i>

AGENDA ITEMS	DISCUSSION POINTS
	<ul style="list-style-type: none"> * Collate and inventory all required data elements – workgroup with local and state * Use parallel process required for federal reporting * Look at where data lives; what it is used for (state vs. federal) – redundant reporting to multiple systems; do systems connect? AOE data untapped; longitudinal system. * Data definition * What whole population and program outcomes do each data point contribute to/link with? Are there redundancies that can be eliminated? Can state agree to give up certain processes, i.e. counting widgets? * Maximize outcome elements, is anyone better off? * Data lives in so many different places/systems, identify plan for how data is pulled together and shared back out in meaningful/easily accessed way. * Land on what data is required, then stick with it – changes are expensive and a lot of work * Consider VT Insights platform for us or for lessons learned as a model * ELC data governance counsel (BBF)
<ul style="list-style-type: none"> ❖ Group Harvest 	<ul style="list-style-type: none"> ○ IFS requires and promotes shared responsibility/accountability. ○ IFS is in part about a culture shift. ○ As a state we are pretty committed to silos. ○ It's important to integrate Reach Up (adults) with children's care. ○ The panel with the two IFS regions helped to clarify understanding of IFS. ○ Funding flexibility and practice-based evidence are important. ○ We need to build bridges between silos vs tearing them down. ○ Inequity in salaries and low compensation results in many vacant positions and high staff turnover. ○ IFS is a tangible way for AHS to act like one agency in a community. It is a vented way to open communication differently.