DEPARTMENT OF HEALTH SERVICES
F-01922 (11/2017)

STATE OF WISCONSIN

OPEN MEETING MINUTES

Instructions: F-01922A

Name of Governmental Body: Children Come First (CCF) Advisory Commitee			Attending: John Bauman, Samantha Feryance, Lynn Green, Phyllis Greenberger, Ron Hauser, Elizabeth Hudson, Rob Kaminski, Ann Kelley-Kuehmichel, Corinda Rainey-Moore, Phil Robinson, Chris Schafer, Carolyn Stanford-Taylor, Scott Strong, Zach Todd, Thai Vue, Nikki Weigel, Dawn Woodard DCTS Staff: Holly Audley, Joanette Robertson, Teresa Steinmetz
Date: 4/24/2018	Time Started: 10:05 a.m.	Time Ended: 2:05 p.m.	
Location: Dane County Job Center			Presiding Officer: Ron Hauser and Phyllis Greenberger, Co-Chairs

Minutes

Welcome and Introductions

New member announcement
Rebecca Bell, Dodge County Director has been selected by WCHSA to join the committee

Roll Call & Approval of Committee Minutes:
Elizabeth Hudson made a motion to approve the January 2018 minutes with no changes. Scott Strong seconded the motion. The motion was approved unanimously.

Presentation: Dane County Children Come First Panel (Moderator: Scott Strong Panel: John Bauman, Benjamin Gonning, Lynn Green, Tricia Johnson, Marykay Wills)

Dane County in the 1970s was known for adult mental health services but there was very little discussion about children's mental health. In the 1980's the county and country started to emphasize institutional care for children and regularly used Mendota with 120 childen on average residing there at any given time. Between 1980-1985, placements at Mendota increased by over 500% and 40% of those placements were shown to be unnecessary.

The National Institute of Mental Health developed a model for reducing psychiatric placements for children, creating community-based care, and tying funding to the family and provided Wisconsin a grant in 1988 to set up a small mental health case management pilot project and keep children out of psychiatric care. This led to a proposal by the state for a Robert Wood Johnson grant to reform systems and expand that pilot. In 1990, the state was awarded a 4 year grant of $2.4 million to expand the project including individualized case planning and changing the preference of institutional care to in-home and community-based treatment. Mobile crisis and school-based mental health began. Very effective partnership between Dane County and Dept. of Public Instruction at that time but only lasted until grant ended. Little incentive for schools to keep children in schools because no financial impact for them when children went to more restrictive care.

A sustainability plan included hiring a Medicaid expert to find a way to fund when grant ended and a Medicaid-reimbursement method to pay for services was developed due to money being saved from residential care. Currently, that funding is only in Dane and Milwaukee Counties and allows current work to be done. State will not approve that funding for other parts of the state. After the grant, the project was called Children Come First (CCF). During the grant, various agencies provided the case management. This was time consuming to coordinate all of the agencies doing the same work.

In 1995, Dane County created a unit called ART (Achieving Reunification through Teamwork) to work with children who were in residential care and this unit still exists. ART allows CCF to work with children who are not in residential treatment because the model only works financially if the majority of children are in community-based care and not in placement. In 1999, Dane County chose Community Partnerships (RISE) to be the vendor of the program to coordinate case management, re-energize the program, work with families better, and push the system forward. This allowed the administrative work to connect with the care coordinator's roles/delivery of the model.

There were a lot of bumps in the road to begin because it was a managed care entity. Many professionals and district attorneys didn't buy in to keeping children in the community, didn't trust the new way to do things and saw the model as just a money saving focus, and preferred to put children in more restrictive care. The effectiveness of the model was not believed. Outcomes weren't available yet about the benefits. Trust was built over time by face to face time between care coordinators and district attorneys/court staff. Had a lot of funding in the beginning but ran at deficit so scaled back. Having too much money thrown at a case was not always helpful – for example having a paid mentor instead of a natural support. There are similarities with this in the development of CCS currently. Social workers did not attend court so did not provide the perspective about the community plan. Challenges existed with how to talk with the courts about the new mental health language.

At the systems level, there was excitement about the new model but also individual cases with families wanting residential care. Families felt like they were not getting the supports they needed. Development of the provider network needed to still happen so there was a time of stress for families. Finding strong community providers who could be available, flexible, and think out of the box was helpful.

This model serves only the highest need children – must be at risk of residential care; it is not a continuum of care. Badger Care HMO used to serve about 20% of those children and now serves about 98% of children. It's a good system with better early detection but there's still a gap for those children in the middle. CCS is starting to fill that gap. Other counties have not been able to do this model due to financial reasons. There have been tensions at the state level about this.

There is a close relationship to risk management. Had many discussions to develop roles of social workers vs. care coordinators, developed policies and practices, how to work with the courts, how to talk with families. How care coordinators spend the funding is individualized. Although there is a per diem per child per month, there is an ongoing review of services, goals, outcomes, and progress. There are team discussions about how the money is being spent and why. This process coordinates with other counties by utilizing CST as a wraparound approach and using CCS as the funding source. The big concern statewide is that CSTs are not individualizing services according to the needs of a child and instead piecing out resources when they can. Ideally, the CST funding would be used to move the system forward and CCS would pay for care coordination and services, and CST could use funds to pay for non-Medicaid related needs.

Providers struggle to represent the population served and there are challenges finding providers that work with specialty populations. There have been ongoing efforts to expand the provider network. There is flexibility to bring diverse providers on board (such as a shaman) to find alternatives for children when needed. There is more effort now to build on children's assets versus punishing children in the courts. Having access to flexible funds is beneficial with this and judges and courts are willing to be creative.

It's important to have school representatives on teams because children are at school so much. Partnering with the districts in the county is critical and explaining what wraparound is and why it works. Having families talk with schools is helpful and often gets left out. Schools

struggle with children who have extreme needs and there are children being expelled who should have other options. There also needs to be buy-in and training with school leadership/principles and boards.

Creating a county mental health collaborative has been successful in engaging leaders in the community to help promote change. The right people at the table is important. Having school leaders and board members at the table helps.

When parents are overwhelmed, more concrete information and resources are needed. Values and principles feel "squishy". Having hands-on help and respite is great and results in less symptoms. Education around mental health needs to happen (that it's 24 hours a day and challenging for families), especially with schools.

Developing relationships with formal and informal partners is crucial early on. Backing up those relationships needs to happen or the relationship is tarnished. Need to have good care plans that care coordinators are invested in. Care coordinators need to be a different person than the person enforcing the court order. Could be a county worker but challenging for children welfare workers – usually don't maintain fidelity to the model. The role of the care coordinator is to facilitate the team, ensure parent voice and choice, and help the team make decisions and do the work. True collaboration happens from the bottom-up, not the top-down. The leadership needs to set structure and policies, and help people focus on 'doing' right vs. 'being' right. Administrative buy-in is critical with reviews on data and outcomes. System collaboration is an ongoing consideration and needs nurturing – having a committee that pays attention to cross system communication and change with parents at the table. Make sure there is a good crisis system for parents to support them afterhours, when things fall apart.

Need to own what you are good at and not. In Dane County, serving children with substance use needs doesn't work well with this model. Need to be honest with parents and partners about this.

The vision and mission need to continually be reviewed and pushed forward with the family being a primary voice. It's hard to change systems and need to keep working toward the goals. Wraparound implementation is a parallel process. It's a new way for families and also needs to be worked on with organizational leadership and staff.

Additional information about RISE and Dane County's CCF program is attached.

Member Spotlight

a. Lynn Green, Dane County Human Services
b. John Bauman, Dane County Juvenile Court
c. Scott Strong, RISE

Next month's spotlight members:

a. Thai Vue, Mutual Associations, Wisconsin United Coalition of Mutual Assistance Associations, Inc.
b. Elizabeth Hudson, Office of Children's Mental Health
c. Ron Kaminski, Parent

Update: System of Care (SOC) Workgroup

The DCTS internal system of care workgroup is developing guidance and documents for sites providing CST and CCS. Staff met off-site earlier this year for a full day and decided to prioritize meeting together every other month off-site for full days to work on pointed projects. These will occur prior to the external workgroup meetings to provide them materials to review. Next priorities are: scheduling joint site visits, developing training, and a focus on coordinating committees. Additional workgroups are now in place for setting the agenda for joint site visits and another to focus on training. The next meeting will be May 4.

The external workgroup met on March 16 and discussed priorities for future meetings, and how the workgroup is addressing the priority recommendations. A major area to address is how to better define the children's mental health system differently than the adult mental health system. Also brainstormed future topics to address. Some challenges include treating children in an adult practice manner, involving the Division of Quality Assurance with practice and system change, supervisors needing training to assist with system and culture shifts, care coordinators buying into wraparound principles, coordinating committees, and philosophy differences between long-term care and mental health.

DCTS has approved and published a common language document, and a guiding document for building a system of care. The principles of wraparound are approved and part of the guiding documents. Soon all of the documents will be on a system of care website being developed. Staff are working on a system of change developmental phases document as a guide for both state staff and site staff.

Follow up regarding panel presentation:

- Fidelity to the model is challenging over time and needs ongoing attention. Drift back toward homeostasis is automatic.
- The state could provide more guidance and forms regarding services (similar to CLTS) to counties and providers.
- Getting counties together for discussion and support is helpful.
- A training academy to train site staff collectively with the same message is more impactful.
- What do families need to do to pressure systems to have fidelity with the principles?.
- Helping parents speak the language of the counties/systems they interact with. Clarify who is in charge of CCS – is it providers or the county? Who do parents go to with needs, questions, and concerns? Helping parents learn to advocate as part of the team instead of us vs. them.
- Management level of training and orientation for those who manage the array of supports and translates services, implementation, and funding.
- Top down and bottom up approach together = Top down with administrators who buy-in and teach managers how to communicate and support parents and staff. Bottom up with parents working to advocate and challenge the system.
- Develop systems to monitor process – how are services being authorized and why. A review to develop a plan to improve and move forward. A partnership to assist sites, not monitoring to ding them. Accountability that leads to skills development, relationship building, etc. Framing this in a strengths based way.
- Providing coaching/technical assistance to build the system of care, documentation, principles. Individualized for each site.
- Identifying gaps where services do not exist or aren't working. Having a point person for parents to contact no matter what. Teaching providers to be honest about what they are and not able to do – building trust and transparency.
- Is there a commitment between state and county to work together toward system change?

Legislative Update

Phyllis Greenberger reported that 17 year olds are still considered adults in the criminal justice system. There has been and is ongoing advocacy to change this and perhaps it will be put into the budget.

A bill passed to approve the following. Lincoln Hills and Copper Lake will close by law and become an adult facility. DOC will continue to have at least one Type 1 facility. Mendota will obtain at least 29 more beds, doubling the current number. Human services will need to approve Mendota placements. DOC will be operating a serious juvenile offender program and working with youth with adult sentences. Other youth will be served through the county, not through DOC. There will still be county detention and secure residential care centers run by counties or consortium of counties, and counties can apply for state grants to pay for capital costs, 95% for boys and 100% for girls. There are two new committees being created. Milwaukee will have its own services.

Corinda Rainey-Moore reported there have been legislative changes around the Affordable Care Act. A bill passed around increasing pilot sites to provide dental care using Medicaid funding but nothing has been done to move funding to assist with it. Dental health care is often downplayed yet plays a critical role in health. Several proposals passed to reduce premiums in the marketplace and for persons to pay child support or lose their medical benefits. For persons in child support arrears to lose healthcare is problematic.

An overview of recent legislative action on health care bills has been compiled by Kids Forward and is attached.

Wrap Up

Future meetings:

Vision of CCS and expectations to move it forward
Tim Connor - data

Training and education around CST and CCS to county board members and county directors

Prepared by: Joanette Robertson on 4/25/2018.

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