

Connecticut Outpatient Learning Community

Family Engagement Work Group

September 27, 2010

MINUTES

PARTICIPANTS: Suzanne DeRosa/CMHA; Hal Gibber/FAVOR; Jacqueline Harris/DCF; Jennifer Nadeau/CHR; Joann Maben/US; Lois Berkowitz/DCF; Bert Plant/DCF; Lou Ando/CSSD; Marcy Kane/Wellpath; Ava Hart/Middlesex Hospital; Sherry Perlstein/CGC of Southern CT; Cliff Johnson/CCGC; Lily Gill/UCFS; Catherine Corto-Mergins/The Village for Families and Children; Christine Dauser/Yale Child Study Center; Debra Struzinski/CT BHP; Doriana Vicedomini/CBHAC/CAAC; Hillary Teed/CCPA; Danielle Chiaraluce/Families United; Teresa Fazio Winters/CT BHP; Sarah Lockery/The Children’s Center of Hamden; Kim Monahan/CHH; Susan Zimmerman/Parent Advocate; Peter Forte/CT BHP; Jeanna Sparta/FCA; and Marilyn Cloud/DCF.

TOPIC	DISCUSSION	ACTIVITIES & DUE DATES
1. Welcome/Introductions	❖ New members were introduced and welcomed.	❖ See Participant List above.
2. Review of Work Products	❖ Minutes of 8/23 were approved.	
	❖ The definition of Family Engagement was approved, with the understanding that this is a tentative definition that may be modified as we continue our learning and research relative to family engagement.	❖ See attached Definition – Family Engagement document.
	❖ Core Values and Principles of Family-Centered Practice was approved, with the following modification: ○ #3- Added “Child-Focused” to introductory	❖ See attached Core Values & Principles document.

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	bullet. Now reads “ Child-Focused, Family-Centered.” <ul style="list-style-type: none"> ○ Inserted # 15 “Natural Supports” under # 5 “Culturally Relevant.” 	
3. Intake Process & Packets: Presentations/Discussion	<ul style="list-style-type: none"> ❖ Staff from 13 clinics including 2 hospital-based clinics discussed their intake processes, sharing their most successful, “family-friendly” strategies as well as the barriers and challenges. <ul style="list-style-type: none"> ○ Some clinics operate a triage center with dedicated staff that answer referral calls, ask brief questions that include demographics, insurances, and reason for referral/acuity. ○ Some clinics schedule intake appointment at time of referral call. (At some clinics the clinicians do their own scheduling.) Staff determines best time for appointment and provides directions to clinic. (Note: at many clinics there are few open "prime" time slots, which are reserved for treatment cases, so often new intakes have less desirable times available.) ○ Staff also determine the needs of the child, i.e. trauma history; male/female therapist; language, etc. and try to match to appropriate clinicians. This is not always possible due to access timelines and other barriers. ○ Most triage staff is not master's level and/or licensed, but has bachelor's degrees and experience. Time on call ranges from 10 to 30 minutes. 	<ul style="list-style-type: none"> ❖ DCF expects that each agency will complete a PSDCRS form (found online) to request a Provider Administrator/Super User staff person who can obtain approvals, as needed following the 60-day edit window to make necessary data corrections. To date only a few clinics have done so. <u>Clinic Directors:</u> Please ensure that your agency has a designated Administrative/Super User staff person to manage this critical function.

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	<ul style="list-style-type: none"> ○ It was agreed that this first contact is critical. Triage staff should be warm, inviting, patient, well-trained and competent. Each clinic should have clear protocols. ○ Agencies should have specific QA processes to periodically review first contacts, such as a mystery shopper "walk through." ○ Parents/caregivers need reassurance that they made the "right" decision by calling. Making this call is extremely difficult for many families - the "million pound" phone. ○ If the referral source is non-family, all clinics require that the parent call, although some clinics will enter the data from the referral source prior to the family's call. Other clinics request a release first, with the exception of DCF as guardian referrals. ○ Intake practices vary across clinics, ranging from individual intake sessions to initial group orientation sessions, with the latter delivered by clinicians (at 1 clinic) or intake "technicians" prior to clinician intake session. ○ How families are initially greeted by clinics varies. Some clinics send letter of welcome and paperwork including a checklist of history, the Ohio Scales, etc. via mail, following the first phone call for referral, in advance of the first face-to-face appointment, and other clinics feel this may be efficient, yet unwelcoming. Those who do send paperwork in advance reported a high 	

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	<p>completion rate (i.e. 80%; over 50%) with the completed documents brought by clients to the first meeting.</p> <ul style="list-style-type: none"> ○ There was agreement that having options and choices for families may be best. ○ There was general agreement that all of the necessary information is not captured at one session, particularly the bio-psycho-social history. ○ # of Intake Sessions. Most clinics have only 1 session due to the restricted billing allowance, in spite of the quantity of information that must be both obtained from and given to families. ○ Clinic staff does provide a diagnosis after an initial session, primarily to obtain service authorization. The diagnosis may be provisional at times, however, this can be changed within the 60-day edit window or through Provider Administrator access, if diagnosis changes beyond 60 days of initial data entry. ○ Ohio Scales/Parents are completed at the first session - Universal Practice. ○ A few small clinics have the ability to maintain the same clinician for intake and treatment purposes, but the majority of clinics have separate intake and treatment units, manned by different staff. <p>❖ Peer mentors are used in some areas of the state to provide interim assistance and support to families prior to intake appointment. The CT BHP has peer specialists</p>	

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	<p>that may be available to clinics for this purpose. Some clinics use interns to meet this need.</p> <ul style="list-style-type: none"> ❖ Support groups exist in some areas of the state. ❖ Some clinics train staff on motivational interviewing techniques. 	
4. Wrap-Up	<ul style="list-style-type: none"> ❖ Future Agenda <ul style="list-style-type: none"> ▪ Continue discussion on intake & treatment issues including why families terminate early ▪ Explore resources relating to effective family engagement strategies (i.e. Dr. Mary Mckay research/protocols; State of NY's recent work on engagement and co-construction efforts; ???) 	<ul style="list-style-type: none"> ❖ <u>Next Meeting Dates:</u> 10/25; 11/22/ and 12/20 at 9:30 AM to 11:30 AM at CVH Page Hall in Middletown.