

Connecticut Department of Children and Families
Bureau of Behavioral Health and Medicine

Children's Outpatient Learning Community (OLC)
Legislative Office Building - Hearing Room 1D
October 7, 2010

Minutes

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| ATTENDEES | There were more than 50 participants representing a broad array of stakeholders including families, advocates, providers, and state agency staff. |
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| TOPICS | PRESENTATION |
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| 1. Introduction | <ul style="list-style-type: none"> ▪ The members of the OLC Coordinating Committee and Tri-Chairs for the Data QI and Family Engagement Work Groups were introduced. ▪ The agenda was reviewed. ▪ Dr. Robert Plant, Director of Programs and Services/DCF briefly reviewed the background, purpose and objectives for the Outpatient Learning Community. |
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| 2. PowerPoint Presentation - OLC: A collaborative process towards service improvement Various Presenters | <ul style="list-style-type: none"> ▪ The activities and work products accomplished to date by each work group - Data Quality Improvement and Family Engagement were presented. ▪ These presentations included: a review of the Definition of Family Engagement; identification of Core Values and Principles for a Quality Data System; and Core Guiding Principles for Child-Focused, Family-Centered Practice. (Please refer to the attached PowerPoint and related documents for details) ▪ There was general consensus regarding the value and content of these work products. ▪ This was followed by a group discussion of potential next steps including: training on evidence-based family engagement protocols; methods to assess engagement/satisfaction; use of Youth Services Survey - Families; data quality improvement surveys - online and through focus groups; and review of PSDCRS reports. |

| TOPICS | PRESENTATION |
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| | <ul style="list-style-type: none"> ▪ Again, there was general consensus regarding moving forward in these directions. ▪ Lois Berkowitz provided an update regarding the status of the ECC work groups - Child Co-Occurring and Access/Service Capacity, the latter to be scheduled shortly. |

| SUMMARY OF GROUP DISCUSSION |
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| <ul style="list-style-type: none"> ▪ How do families feel about group orientation sessions versus an individualized intake session? Reactions are mixed. Some families appreciate the group modality, as being with others makes them realize that they are not alone, whereas other families feel a loss of privacy in the presence of others. ▪ While there is no disagreement regarding the data quality improvement and family engagement concepts, principles and their value, it is quite challenging to apply these due to both internal and external system constraints. Examining the multiple requirements and determining if there can be any reduction or streamlining may be helpful. There is a willingness to do so, however, it was noted that DCF and other stakeholders have no control over many variables, i.e. DSS/Medicaid requirements or federal Mental Health Block Grant requirements. ▪ Karen Andersson suggested that this work could be integrated into the streamlining activities of the CT BHP, rather than the suggestion of having another separate work group. ▪ It would be helpful to have a rationale (source requirement) for each data element, and to identify any priorities. ▪ It would be helpful to have information concerning national data reports and any benchmarking that exists. ▪ Other constraints included: the necessity of rendering a diagnosis following the first session; family barriers to access including inability to use med cabs for siblings who are not in treatment. ▪ Some discussion focused on whether to engage in multiple parallel processes simultaneously versus one process at a time in sequential steps. It may be important, for example, to consider both business and clinical practices together, or to consider how clients engage initially as well as how clients stay connected once they enter the treatment phase. Dr. Bert Plant noted that we began this initiative with the understanding that we would identify small scale, doable activities that would impact the system, rather than extend the scope of work beyond realistic capabilities. The NIATX model for process improvement, which is applied in the field of addiction treatment and recovery, was cited as an example of a successful method that focuses on one process at a time, such as first finding strategies to get client in the door, followed by a focus on retention. ▪ Discussion of next steps for each of the work groups resulted in the following outcomes. <ol style="list-style-type: none"> 1. Family Engagement Work Group |

SUMMARY OF GROUP DISCUSSION

- General consensus regarding exploring and potentially securing training on evidence-based family engagement protocols with Dr. Mary McKay/Mt Sinai School of Medicine, possibly similar to the statewide EDT initiative. This would include identifying measures that demonstrate outcomes on engagement levels and client satisfaction.
- If this is feasible, consideration will be given to: considering cost and determining if benefits outweigh costs; assuring sustainability (not an isolated point-in-time training without identified outcomes as well as assuring the infrastructure to continue what is learned and beneficial; and considering use of web-based technologies for training purposes to eliminate the need for staff to travel off-site, incurring both time and travel expense.
- The potential for wider application of the Youth Services Satisfaction - Families survey was discussed. It was noted that this may require administrative expenses for some clinics that have tailored surveys applicable to their clinics and client populations.
- ❖ Data Quality Improvement Work Group
 - There was general agreement that an Agency Data and Quality Management Survey would be beneficial to assess current resources, quality improvement processes and structures, barriers and needs.
 - Both a brief online survey as well as focus groups to obtain more quantitative information would provide a comprehensive assessment.
- The DCF Training Academy may arrange for PSDCRS training for the provider community, based on needs identified through the survey processes.
- Question: Could there be a consistent schedule for report releases by all sources, i.e. DCF; DSS; CTBHP?
- Question: Will the provider agencies have the capacity to run their own reports for CT BHP and DSS, as they do for PSDCRS? Karen reported that there is a CT BHP Inpatient Dashboard Report and may soon be an Outpatient Dashboard Report.

Respectfully,
Marilyn E. Cloud, LCSW
DCF Behavioral Health Clinical Manager

October 22, 2010