9/29/2016

Comments on CFT issues/status of quality at the local level

(SOC Coordinators' July 2016 semi-annual report)

CFTs tend to vary by agency. The structure of a CFT depends on how the provider chooses to plan the meeting. There is a lack of consistency and structure across agencies.

Overall, CFT members have expressed an openness and been receptive to any participation or insight/recommendations from the SOC Coordinator; even when this information is given within the context of simply stepping into a CFT for one meeting or limited participation. CFT members tend to focus on strictly on youth "placement" and are reluctant to explore use of natural supports and functional strengths as a way to highlight a recovery oriented plan, even when exploring these strategies as a step-down from higher level of care. Noted trend with newly hired counselors (and their supervisors) in that they have little to no knowledge of how to provide case management services, specifically for those Providers that provide an enhanced service in which case managemet should be built into the service. All of my CFT participation has been focus where there has been a r ecommendation for a higher level of residential care and the clinical home/provider had no idea how to initiate this process and the youth began to languish and the caregivern and other CFT members became increasingly frustrated.

Most CFTs involve high clinical discussions regarding the member's progress towards or barriers in reaching goals in their Person-Centered Plan. CFTs are being used to discuss transition planning to lower levels of appropriate care and family stabilization. Noted difficulty with providers not being timely with what is needed to ensure a smooth transition for members.

CFTs that were attended by SOC focused on the issues. . . but hardly addressed strengths or that anything that was going well for the youth. There was a CFT attended by SOC in which it appeared the clinical team lead was unsure of what next steps should be for the youth and the family as the authorization was close to ending.

Possible better utilization of CFT to fidelity.

The quality of CFTs vary. Technical assistance is provided as needed and generally welcomed. The "team" component of the CFT is generally missing. The parent and child are present yet other systems that are involved with the family are missing as well as natural supports.

It continues to appear that fidelity to the CFT model continues to be inconsistent across the provider network. This writer and family partner continue to offer a two day CFT training.

Overall, the quality of CFTs in ____ County are improving. The current trend appears to be the need to fully engage a family and youth before a CFT meeting. There is some engagement, but it continues to be more of the provider leading the meetings and the family and youth following along. There also appears to be less involvement from the family on the strategies to improve issues at home. Families continue to want the youth to be placed outside of the home as oppose to remaining in the home and the family working on issues together. There will be more focus on family engagement during the CFT trainings beginning in September 2016.

Quality of CFT varies, and some providers and systems need reminders to be present at CFT if they are involved with the child/family. Having SOC Coordinator present to assist with SOC guidelines and provider technical assistance appears to be of benefit to the teams.

QPs report overall quality is adequate in most LIII homes that my team works with. SOC (in staffing with QPs) insures QPs are getting team to focus on involving guardians; building natural support systems; insuring specialized needs (e.g. psychologicals, referrals for IEPs, referrals to TFCBT or sex offender therapists, etc.) are occurring; planning thoughtfully for transition; and carefully identifying appropriate transition plans. SOC intervenes in case of crisis or resistance that is to the detriment of the youth. Overall, numbers of youth at this level of care have reduced over the years. Step down plans seem thoughtful and more appropriate when they can occur in a planned way. Care review has insured there is less likelihood that youth are inappropriately placed at this level of care.

Although attendance at CFT is not a requirement of the MCO, we are in the process of restructuring some of the roles and responsibilities which may move us in the direction of supporting some youth that are in LIII or in PRTF placements. As part of the previous SOC coordinators goals, we focused on the fidelity of CFT meetings. We found that when a child residential care coordinator was involved the quality of the CFT meetings were higher, putting more pressure on having the youth present for the meeting. At least for the youth in residential settings, the purpose of the meeting was less specific (being a review of the progress for the previous month). For those youth in the community, the meeting was more structured on offering ideas/support for the family, focusing on action steps. The care coordinators in _____ are using the One Child, One Plan to support this process (for those high need youth, involved with multiple systems.)

Quality varies greatly depending on the provider. Tendency not to include the voice of the adolescent/child. Difficulty in planning transitions from residential to community.

SOC liaisons would like to see providers attend CFT II trainings however CFT it is not required for providers and these training are not requested nor attended when offered.

CFTs were called when teams were struggling to find appropriate services for families. The meetings were appropriate use of time and the focus was to find suitable placement.

It continues to be difficult for CFTs to be family driven. Often CFTs appear tob e cut and dried and not really being strength-based.

Meetings are well attended by treatment providers and stakeholders. Guidelines for true CFTs are not always met, in that there is a rarely a facilitator for the meetings.

Quality depends on who is convening the meeting. Not always true to the CFT model.

CFT quality does depend on provider. CFTs overall are person-centered and focusing on progress/support/needs. Some providers will tend to stress negatives ore than things which are working. Care Coordinators are essential in planning D/C from PRTF LOC in stressing D/C begins at admission. LIII providers do have a longer time to paln for D/C and secure placement. CFT meetings overall have been high in quality and encompass an integrated approach when addressing consumer's needs.

It is a reoccurring theme that if youth is not following the rules the residential program staff may want to concentrate more on challenges rather than strengths and successes.

CFTs are not consistent across the board among providers and levels of care. Some CFT meetings are not using SOC practice/tools/methodology, they are very negative meetings, involve little input from consumer and family members, are often driven by needs of the mental health provider, often times don't even involve the youth, often do not review PCP goals uless asked to do so by CC, and they are not strengths-focused. CFTs could be improved by more open discussion regarding goals and treatment progress rather than reviewing PCP and scripted agenda. Always valuable to have therapist as part of CFTM rather than just GH director or other person facilitating the meetings. The ones that have been most productive encouraged open dialogue and did not use as opportunity to "lecture" the youth about progress/behavior incidents.

Comments on Care Review Processes

(SOC Coordinators' – July 2016 semi-annual report)

We have decreased the (number) of Care Reviews by holding providers accountable for having CFTs and getting SOC involved prior to needing a CRT. Our CRT process has changed in that we review cases in which the CFT have met and cannot agree on an appropriate plan of care. Our attendance in CFT meetings has increased to make ourselves more accessible to the family and provider and therefore we have decreased the need for Care Reviews. The Care Review referrals received ths quarter were resolved with technical assistance or with a CFT meeting.

Trends for this region: 1) Youth and/or family with trauma history 2) co-occurring MH/SUD 3. Co-occurring mh/idd 4. Treatment provider not addressing symptoms (trauma and anxiety) 5. DSS custody 6. Parents raising grandchildren

The CRTs I attended this month were hosted in two different venues. One was held in a school setting, where the SOC review form is used. The other CRT was held at DSS. No notable trends a vailable based on number of CRTs hosted by each agency.

Trends: Many of the youth had trauma histories, some DSS involvement and/or DACJJ involvement, sexualized behaviors.

Trends: Youth involved with the legal system comprised 70% of the care reviews. Co-occurring IDD/MH diagnoses comprised 12% of the reviews. The CRT made the recommendation for a PRTF placement 21% of the time. The legal guardian status for the reviews was 88% parent(s) or kin, with providers making 67% of the referrals for care reviews.

More consideration is given to the least restrictive environment when considering out of home placement for youth. Technical assistance was requested during their CFTs from SOC and care coordinators so the number of care review request have decreased increase in Wright School referrals.

Based on care review referrals, it seems that many CFTs still seek CR to get "endorsement" for placement. Education about ow the CRT cannot make a clinical recommendation for a specific level of care or guarantee what UM will approve, or not approve, as meeting medical necessity continues. It appears too that many CFTs think often that placement is the only option, and seeking community based resources is not utilized enough.

It continues to seem that some providers struggle with how t carry out case management functions now that case management is not a stand-alone service (e.g. when children/youth are in juvenile detention, jail, or psychiatric hospitals and Medicaid can't be billed; when an individual is getting only OPT and/or

medication management; when an authorization for a service has ended but the individual is not yet linked to the next service/support; etc.) This affects "seamless transition" from one service and/or provider to another service and/or provider.

The CR process continues to be a technical assistance need with stakeholders of the community, families, youth and adults. The purpose of a CR continues to be an issue in that the thought is that a CR determines level of care and placement options. The SOC Coordinator provides training and technical assistance to stakeholders to assist with the purpose and need for a CR. The referrals are increasing and the CR appear to be successful for those families/adults that participate in one.

Focused CRT meetings led by the SOC are child specific and held in the community at a location convenient to the family and involving agencies relevant to the child's situation, usually within several days of the request for review. These are done prior to consideration for Level III and PRTF placement. Focus is on getting DSS, DJJ, and clinical home to be detailed in work they have done with family prior to getting to the point of Care Review. This is a continuing education process for DSS and DJJ. SOC also staffs case with clinical home prior to care review. This often assists clinical home in deciding prior to care review what clinical supporting information is needed; appropriate level of care to request; what resources have already been provided and what resources are available in that county; who needs to be at meeting; and information about the client that needs to be clarified before entering care review.

SOC also participates in Child Fatality Taskforce/CCPT teams in six counties when possible or assigns QP she supervises to go to meetings. This is the vehicle through which complex cases are discussed by all county partners who are aware of resources available and who brainstorm on ways to provide services to the families. These meetings serve as large care review teams in the catchment area. SOC or QP will begin attending DSS Permanency Planning meetings, another form of review team for children in foster care.

Trends still seem to be those cases where the family has intergenerational trauma, grandparents raising grandchildren. It seems that the community is doing a better job encouraging the youth to be present whenever possible. The care review panel is doing a better job at looking at the bigger picture and not just the behavioral healthcare needs. For example, for the parents who completed our survey, 94% reported that the care review provided suggestions or ideas addressing several life domains. 94% reported that care review was helpful in offering some realistic suggestions or ideas to explore. For our web-based referral system, 93% reported the system was user friendly. Other data that was collected showed that, of the cases surveyed, only 67% reporting having a CFT every 30 days. We also found that only 60% felt fully prepared for the care review process, 33% felt somewhat prepared for the care review and .06% felt not at all prepared. We continue to partner with (Family organization) to have a Family Partner reach out to the family to support the understanding of this progress. We have also reached out to treatment providers (clinical homes) to ensure they are preparing families for this meeting. If there is a care coordinator involved in the case, the care coordinator is also doing education about the structure of the care review and what to expect. At the beginning of each meeting, there are visuals as well as a discussion about the purpose of care review and what to expect. There is also a written detailed agenda that is followed.

Many of the youth had trauma histories, some DSS involvement and/or JJ involvement, sexualized behaviors.

MCO had a CRT process for the period of time covered in this report. Recently it was determined, as of july 1, 2016, Care Reviews will no longer be conducted unless specifically requested in circumstances for which CFT teams need external input regarding options for placement, community resources and/or assistance to address other needs of the family. MCO's intent is to increase fidelity of CFT meetings conducted by providers and ensure families participate in the process.

[Fewer] CRTs were [requested] and the one that was called was a situation that the community was most effective in problem-solving for appropriate services for the family/child

Sexualized behavior services are needed in all three counties. Children's Hope Alliance now offer some services as well as Alexander Youth Network. The community have also see the need for additional support. We will be looking at data collected from MCO as well as other agencies to see how best to address this issue.

MCO has discontinued the Care Review process and encouraged an enhanced CFT attended by Care Coordination.

Referrals made by teams who have exhausted known resources, and by teams exploring higher levels of care. This was a very positive experience for the family and treatment team. We also had exceptional follow up from the CRT facilitator requesting feedback on outcomes 2-3 months after CRT. I do believe that the recommendations made and the care shown during the team made the family feel more supported and prevented an out of home placement.