Iowa System of Care Summit
Monday, April 4, 2016
Comments from Morning Self-Reflection, Small Group Work, and Report Out

- Need better definitions in defining roles of providers; private vs. state
- Desired Outcome #6: Feel maybe DHS may not have the time and could use the provider knowledge for better matches
- Maybe more $s for having kids better prepared for return home for more upfront services
- How do we not change providers when they go home – kid is working with one person then when they get home it is a new one person – provider consistency
- There are resources available in the community that could be better utilized
- Desired Outcome #9: Private providers do not have control of where children are placed
- “Shelter” has fewer than 25%-30% of parents that visit while in shelter
- Desired Outcome #15: DHS workers need to be returning phone calls to kids in shelters – even when there is no update
- Provider collaboration between agencies versus doing it all under one roof
- Community support services that can be utilized after services are transitioned out
- We like desired outcome #14
- Better use of outcomes should measure things we have control over e.g. not just how many times we call police
- Changes in DHs licensing practices that allow siblings to be placed together
- For shelter, foster group care, and PMIC, better more intentional and thoughtful concurrent and discharge planning
- Define EASY, STREAMLINED process to share information necessary for diligent family finding
- <u>Leadership supervision</u> to include positives, how can I help you more? What success have you had this week? Focus on positives of families and employees.
- Child welfare new staff training: structure differently by providing application and context such as critical thinking skills – this will also create trust building amongst public and private sectors

- Child welfare new staff training: shared/joint training with private and public sectors
- Identify resources for families to "help themselves"
- Creating more fluidity with funding streams, flexibility in how funding is used. Doing so leads to more collaboration between providers and funders/state
- Identify what the BIG P policies actually are to begin to allow providers and the state to serve families in the best ways possible
- Providers need to collaborate more
- Blended funding/flexibility; pooling funding
- Case rate for children and families
- Begin with the end in mind…make successive approximations over next three years to get there
- Merger of contracts…out of home care kids more around within this system as they need to and are prepared to
- Not all providers can do this: financial challenge: immediately take on a financial risk
- Does a change in case rate payment methodologies improve desired outcomes?
- Performance measures → outcomes
- Payment for sharing between providers
- Payment structure for tangible needs many families have
- Providers reduce duplication of services; integrating the existing coalitions, alliances, multidisciplinary meetings, etc.
- Knowledge of services that are offered and how they are available to our students
- What is the assessment process on what services are needed – need a qualified person
- Truancy/safety/transportation
- New hires to do in-home
- Who offers what across the state – red tape
- State have to have after hours (high speed internet) to communicate with their kids

- Engage MST at front end
- Are there restrictions for certain kids – some kids are not safe in that home
- Referral follow through such as marital counseling
- Evidence based practices/outcomes/expenses for finding providers
- Advocacy/input into payment/rates/incentives – TRUE belief in a partnership
- Flexibility – regulation, prescription approaches
- Agency/community partnerships: who is good at what; sharing best practices; coming together
- Family-centered assessment: accurate and thorough picture of sources of dysfunction
- Family engagement: tools, resources, proximity
- Family engagement is critical
- Shelter-limited decision making ability. Child placed by DHS/JCS: no plan/plan is not feasible
- Once child is placed – worker moves onto next crisis
- More intentional action when obvious gaps of service exist
- Changing mindset re: family home visits (earn/privilege vs. expectation)
- Current system does not have flexibility to address broader socio-economic/health issues of children and families (Prevention and early intervention needed). Funding. Capacity. Need flexibility.
- More partnership approach, better alignment of not just human services, but health care, education, juvenile justice, etc. Break down the silos.
- Streamline program, funding for families
- Getting more access to care in the homes, especially in rural communities
- Providers need to be trained to work in the home
- Collaborating with agencies to get child best care closer to home
- Be ready to have our mental mindset changed. Things will be so different in the future
- Need to make sure qualified therapeutic foster parents are incentivized to keep kids longer

- Streamlining administrative expectations (audits)
- What do we have to change: finance system; unified philosophy about what is best for child i.e. JCS, judges, school; staff support and training; outcomes of substance not process; have people to hire that stay; flexible/necessary support system
- How do we encourage systems and agencies to identify early on a positive adult relationship that may not be a biological parent?
- Right services, right time, right dose → assessment and referral process and data sharing
- Who ultimately makes the decision to place kids back home?
- Treatment court model is much more in-line with these outcomes vs. traditional court
- Define therapeutic foster care
- Identify how families define their family. Engage with each family around that definition. Ensure families have connection.
- Listen to our community – ensure out approaches meet that community
- Rework the definition of “who” and “when” we involve people in the planning process
- Ensure all staff are provided opportunities to be a part of their community
- Work with managed care to engage them from a population health perspective
- Earlier interventions that are supportive; not a checklist
- Define what is services without walls in the community
- Rework our training to include where we are headed
- Keeping the vision at the forefront
- Continued improvement in family engagement
- Providing the necessary support for foster parent/bio parent interaction
- Being truly family centered
- Three generations of clinicians: YOUNG – Safety net integrated; MID – Some integration but pulled between family life and work balance; OLDER – clinicians drive the case and are not seen as team member

- Cross sharing of data (medical, IME, education, insurance, Medicaid, school, mental health services)
- Collaborative analysis of data
- Having system support in local community to develop innovative practices
- Consistent paradigm of treatment
- Higher level collaboration on overall prevention – Ownership
- New level of prevention
- Different ways to staff – flex hours, shared caseloads (staff wellness)
- Building in strategic investments into overall budget – low administration percentages affects ability to do this
- Invest in a family's needs – housing stability – don't look at needs being only clinical
- Keeping a big picture view of family
- Serving young children – ages 8 to 11 – who have serious mental health/behavioral concerns
- Provider: What can Change? What needs to Change?
    - More data collection
    - Permanent adult support – family appointed
    - Agency integration – across program meetings
    - Collaboration across sectors (physical, mental health, education)
    - Update screening assessment tools
    - Improve communication, trends, future vision of services – know what and why we do what we do…
    - Expand trauma informed practices
    - Training – funding/support and staff safety (new levels of risk)
    - Family finding begins day one
    - Satellite offices or more in-home MH services (churches, schools…)
    - Rate methodologies
    - Audits – punitive recoup "word games"
    - In-direct (time studies, space utilization) does not improve service of child or family
    - Funding for basic needs: transportation, food, etc. Meeting basic needs before we move into clinical work. Basic needs impact engagement, stress/neglect/abuse, attendance