MASSACHUSETTS Caring TOGETHER:
The Journeys and Practices of Two Oversight Agencies in Implementing Residential Best Practices

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What is Caring Together?

- Department of Children and Families (DCF) and Department of Mental Health (DMH) jointly developed a new approach to provide children and families with residential and support services.
- Joint Procurement of congregate care services built on the foundation of BBI principles.
- Service system is jointly managed and utilized by DCF and DMH.
Caring Together Vision

Families are the center of the design, development and delivery of services and supports they need.

Executive Office of Health and Human Services (EOHHS) and the Agencies envision a system wherein Massachusetts children and families have timely access to an integrated network of out of home and in home treatment services and supports that reflects their voice, is responsive to their needs, and strengthens their ability to live successfully in their local communities.
Joint Standards

- Maximizes Family Engagement
- Practices that promote Permanency
- Positive Youth Development framework
- Work on Transitions and Bridging from care
- Culturally Responsive interventions
- Work with MA Interagency Restraint & Seclusion Prevention Initiative
Intentions

- This initiative was intended to:
  - Achieve better / positive outcomes for youth & families
  - Engage youth, families & providers
  - Create continuity of providers for families
  - Connect residential services to the community and out of the “brick and mortar” of the program
  - Usher in new models and methods
Intentions

Caring Together does not:

- Change the mission or mandate of either agency
- Change the way that youth / families become approved or authorized for services with either agency
- Combine the budgets of DMH and DCF. Each agency will purchase services using its own dollars
- Shift the service provision responsibility of either agency, even though services may be jointly purchased and managed
- Mean that both agencies will purchase all of the services being procured. Some services are specific to agency service mission/mandates or population
Caring Together Fast Facts

- **Population Served**
  - MA State Population: approximately 6.8 million
  - **DCF (4/2017 point in time)**
    - 12,119 youth in DCF custody
    - Approximately 2260 youth receiving Caring Together services
  - **DMH (4/2017 point in time)**
    - 2828 youth receiving DMH services
    - Approximately 400 youth in Caring Together services
Caring Together Services

- IRTP
- CIRT
- 766 Residential Schools
- Group Home: multiple levels
  - Intensive Group Home
  - Group Home
  - Pre-independent living
  - Independent living
- STARR (Stabilization and Rapid Reintegration)
- Continuity support services for youth in GH or Res Schools
  - Follow Along and Stepping Out
- **Continuum Services**
- Teen Parenting programs
- Specialty programs (Medical, College Prep.)
System Management

EOHHS

DCF

CTCS:
Caring Together Clinical Support Teams

DMH
Joint Management Structure (CTCS)

DCF and DMH Co-Directors

DCF Asst. Director

DMH Asst. Director

5 Regional Teams
• Clinical Supervisor
• Clinical Social Workers
• Integrated Practice Specialists
• Network Specialists
• Coordinators of Family Driven Practice
Systemic Family Involvement

Systemic Inclusion of Families

Provider Implementation Advisory Committee

Outcomes Survey Workgroup

Continuum Practice Profile Workgroup

Family Advisory Council

Quality Improvement Workgroup
Innovations in Residential Practices

Continuum

Service Description:

The Continuum service is provided by a Continuum Core Team (clinician, outreach staff and youth peer mentor) in consultation with the Continuum occupational therapy and psychiatry consultants.

The Continuum coordinates and provides an array of interventions individualized to meet the unique needs of each youth and family in a manner that is culturally relevant, family-driven, youth-guided, trauma-informed and strength-based.
Core Elements of the Continuum Service

- Family and youth are provided with a Core Team: Masters level clinician and outreach staff supported by peer mentor, and psychiatry and OT consultation.
- Continuum allows family to not have to “start over” as the team will follow youth and family through various levels of service.
- There is a unified treatment plan, regardless of level of service, coordinated by the Core Team with the residential provider.
- “Residential without walls” – skill building is supported at home and in community.
- Respite
Innovations in Residential Practices

Coordinator of Family Driven Practice

- CTCS staff position dedicated to advancing family driven practice in the Caring Together system
- Caring Together designers created this position to ensure the vision kept its focus
- Perform support, training, and coaching across Caring Together
- Continuously supports the importance of family driven care and inclusion of family voice at every level
CFDP Residential Consultation Results

- Attendance in multiple treatment meetings for various youth and families
- Interface with program and agency to discuss family centered approach (family specific)
- “Resetting” with the family in a partnership (addition of Family Partner, overall immediate change)
- Programmatic changes in approach and expansion to other programs within the agency
- Trainings with program followed (included other CTCS team members - record reviews, community connectedness, family driven practice train the trainer)
Lessons Learned

Continuum

- **Challenge:**
  - Procurement process only outlined contractual elements, not practice elements of the service
  - Practice elements needed to be more clearly defined
  - Families reported that service was not consistent across all providers
  - Respite can not always be accessed
Lessons Learned

Continuum

- Remedy:
  - Development of Continuum Practice Profile
    - Multi-stakeholder process
    - Process was an intervention
  - Strengthening creativity with respite
  - Developing out of home respite
Continuum Core Elements

1. Practicing cultural relevance
2. Engaging youth & families
3. Conducting a comprehensive collaborative assessment
4. Collaborative care coordination
5. Assessing risk, safety planning, & supporting families through crisis
6. Incorporating psychiatry & OT consultation
7. Providing intensive therapeutic interventions
8. Ensuring continuity with higher levels of care
9. Bridging community integration
10. Strengthening well-being through respite
11. Supporting life transitions
Development of Practice Profile: Results & Insights

- Participants acknowledged and valued the knowledge sharing and learning that occurred in multiple directions.

- Built consensus about what constitutes quality Continuum practice.

- Having an Occupational Therapist at each session led to a breakthrough understanding of the OT role.

- Many themes repeat across the Practice Profile components and are inter-related. The core components and activities are not linear.
### 3. Collaborative Care Coordination

The Continuum Core Team engages in a structured collaborative care coordination approach that promotes continuity in treatment planning. The Family Team, which includes family members, referring agency, out of home treatment providers, Continuum OT and psychiatry consultants, other treatment providers and services, community resources, and natural supports, work as a group on the development, implementation and amendment of the youth and family’s Treatment Plan/Individualized Action Plan (IAP). The process is family and youth guided, strengths-based, collaborative, outcomes-driven and tailored to the needs of the individual youth/family; and takes into account the family’s circumstances, culture, and readiness to participate. The Family Team comes together around the youth and family’s prioritized needs, and sets measurable goals and objectives, identifies interventions that are most likely to succeed and specifies who is responsible for each piece of the work. The Continuum Core Team takes the lead role in facilitating collaborative treatment planning and service coordination whether the youth is living at home or in an out of home treatment intervention (group home).

Please see the following matrices for additional information related to collaborative care coordination: Bridging Community Integration, Supporting Life Transitions, Wellbeing through Respite, Ensuring Continuity with Higher Levels of Care and Incorporating Psychiatry & Occupational Therapy Consultation.

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<thead>
<tr>
<th>Ideal Practice</th>
<th>Developmental Practice</th>
<th>Unsatisfactory Practice</th>
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<tbody>
<tr>
<td><strong>Establishes a Family Team</strong></td>
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<tr>
<td><strong>SE</strong></td>
<td>Reviews the purpose and role of the Family Team with the family, including how it may be different/similar to other types of team meetings. Ensures that youth and family know that Family Team membership can change over time as youth/family needs change.</td>
<td>Gives a broad explanation of Family Team that fails to clarify how it may be different/similar to past team meetings the youth/family may have experienced.</td>
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<tr>
<td><strong>SE</strong></td>
<td>Explores and identifies, with youth/family and referring Agency, the individuals they wish to include on the Family Team. Considers whether there are important &quot;missing” Team members (such as Family Partner, group home staff, medication prescriber, school personnel, peer mentor, DMH case manager/DCF social worker, non-custodial parent, caregiver, therapist, natural supports, etc).</td>
<td>Explores Family Team membership once without regularly exploring any new supportive people in the youth/family’s life that they would like to invite to join the Family Team. Fails to recognize potential key stakeholders or asks limiting questions that aren’t broad enough to help solicit potential team members.</td>
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<td>Only explores professional/formal supports as potential Family Team members to the</td>
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### Lessons Learned: Family Driven Practice

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<th>Challenge:</th>
<th>Remedy:</th>
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<td>- Limited bandwidth to support providers and state agencies in their approach to family driven practice (only 4 Coordinators of Family Driven Practice statewide)</td>
<td>- Create individualized strategies with both providers and state agencies</td>
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<td>- Process to address this work is not fully defined</td>
<td>- Use “train the trainer” approach</td>
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<td>- Supporting other CTCS team members in truly embracing family driven practice</td>
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<td>- Practice persistence: “what you focus on grows”</td>
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Future Considerations

**New working relationships**
- Many staff in Caring Together leadership roles within both state agencies are new and developing working relationships as we move forward

**Sharing data**
- Both state agencies are working on ways to look at agency specific data, as well as create new data platforms that will work for both state agencies

**Coaching and training**
- Developing creative ways to fund coaching and training opportunities

**Keeping things simple**
- Working to address complications and unintended consequences of the collaboration and focus on agency needs
Questions??
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