OFFICE OF THE GOVERNOR
STATE OF CONNECTICUT

Governor's Task Force on Housing and Supports for Vulnerable Populations
Legislative Office Building Hearing Room 1A
January 24, 2020, 10:30 am – 12:00 pm

Minutes

Task Force Members Present*

Office of the Governor	Senior Coordinator for Housing/TOD Lisa Tepper Bates
Beacon Health Options	Robert Plant
Department of Aging and Disability Services	Commissioner Amy Porter
Court Support Services Division, Connecticut Judicial Branch	Executive Director Gary Roberge
Department of Children and Families	Deputy Commissioner Michael Williams
Department of Economic and Community Development	Tom Hyde
Department of Developmental Services	Commissioner Jordan Scheff
Department of Mental Health and Addiction Services	Commissioner Miriam Delphin-Rittmon, Kim Karanda, Fred Morton
Department of Social Services	Commissioner Deidre Gifford, Kate McEvoy, Bill Halsey
Office of Early Childhood	Commissioner Beth Bye
Office of Healthcare Strategy	Director Vicki Veltri
Office of Policy and Management	Scott Gaul
Supportive Housing Works	David Rich
Connecticut Health Network	Sylvia Kelly
Connecticut Hospital Association	Liz Beaudin
Connecticut Nonprofit Alliance	Gian-Carl Casa
Leading Age CT	Mag Morelli
Partnership for Strong Communities	Kiley Gosselin
United Way of CT	Rick Porth
Department of Housing	Steve DiLella
Statewide 2Gen Coordinator	Rosa Rada
HUD Hartford Field Office	Suzanne Piacentini

** Leadership of participating entities may elect to appoint a designee*

Task Force Members Absent

Department of Energy and Environmental Protection	Michael Li
Department of Labor	Deputy Commissioner Dante Bartolomeo
Department of Correction	Director of Reentry Services William Murphy
Department of Transportation	Dennis Solensky
Corporation for Supportive Housing	Christi Staples
Mental Health CT	Luis Perez
Connecticut Coalition to End Homelessness	Richard Cho
Department of Public Health	Commissioner Renee Coleman-Mitchell
CT Housing Finance Authority	Terry Nash

I. Call to Order – 10:30 a.m. Minutes approved unanimously. Call for speakers: no members of the public identified themselves to speak.

II. Understanding and Responding to the Needs of Families
   a. OEC Commissioner Beth Bye introduced Skylight, a contractor that is providing support to OEC under the Federal Preschool Development Grant to OEC. Lar Kohl, Skylight, presented research regarding the experience of Connecticut families facing homelessness and seeking assistance from multiple systems. (Presentation attached.)
      i. Resources available to struggling families are scattered across agencies, require multiple applications and multiple contacts, are not consistently available; parents cited a desire for more coordinated access to the range of services/supports that they need.
      ii. Other common themes:
         1. Young families struggle with adults having no established credit, education, or work history
         2. Expecting mothers have a difficult time finding work. New mothers cannot work while caring for children that are younger than school age.
         3. Intimate partner violence is common.
         4. Families led by fathers or with teenage boys have difficulty finding space in homeless shelters.
         5. Parents reported consistent immediate and long-term concerns including desires for: parenting classes; improved financial management skills; improved education and employment prospects; counseling; education/Head Start for their children

   b. Emerging Best Practices to Serve Families in Need – *Elaine Zimmermann, Regional Administrator, Administration for Children and Families.* Ms. Zimmermann presented on the findings of a six-state ongoing initiative to support families in need. Ms. Zimmermann underscored the Administration's commitment to efficacy and to removing federal barriers from promotion of optimal health and wellness, and invited participation to help achieve this. (Presentation attached)

i. As part of the project, ACF interviewed hundreds of families; the gathered narratives were compiled by Delloite and Touche into composite vignettes with associated names and faces. ACF disseminated the stories shared by stakeholders to decision-makers.
ii. Now in the third year, this effort is focused on jobs, including a whole-family approach to jobs.
iii. Working across parties has been important and possible by agreeing that there will not be voting on anything.
iv. By looking at what in government is getting in the way, what aspects of these obstacles are under federal versus state concerns, and how can things be better aligned, there is wide participation; inviting stakeholders with the aim of listening to each stakeholder's needs and preferences and identifying the common issues has permitted deeper listening and faster passing of bills.
v. Lessons learned include:
    1. Inviting unexpected stakeholders leads to better results
    2. Each stakeholder has different priorities, and shaping language to match their priorities is helpful.
    3. Identifying the values of the customer generates buy-in and political will.
    4. The Two-gen (concurrent parent/child assistance) is highly effective and requires a great deal of social capital. Housing, food instability, and childcare all coexist.
    5. Anticipation of consequences or "cliffs" of social programs is important.
    6. Often there are stakeholders or support services working within the same domain and geographic location but who are unfamiliar with each other's work.
    7. Training and education of leadership including training for culture change is critical. (New Hampshire is training its leaders in collaboration, emphasizing the value of talking honestly about what one is quietly concerned about.) Training for middle layers of leadership is important; without this, none of the proposed changes were going to be operationalized.
    8. An entrepreneurial emphasis on social determinants of health is widespread in clusters nationwide. Data collection on transportation options, pharmacy locations, food deserts is underway.
    9. The Surgeon General is looking at economic mobility as a social determinant of health. Next week, several federal agencies including HUD, OSHA, Civil rights, and HIPAA are gathering to explore this.

III. Update on Task Force's Frequent Multi-System User Pilot

a. Dr. Robert Plant, Beacon Health Options – 500 Familiar Faces Data Match Update (Presentation attached)
    i. Dr. Plant noted that Beacon Health Options, under the auspices of Connecticut's Behavioral Health Partnership (a joint effort of the Departments of Social Services, Mental Health and Addiction Services, and Children and Families) is the lead on the data match. He noted that this particular match is the first of its kind in the state, pulling together data from multiple state systems in one match.

ii. He emphasized that the partners developing the data match concept for the Task Force repeatedly acknowledged that this effort is a starting point with regard to leveraging data cross systems, and as such the group aims to make it as good as it can be while recognizing that they should not be daunted by fears of imperfection. In order to move the process forward as quickly as possible, the team is capitalizing on existing data agreements and relationships.

iii. Data sources include: Homeless Management Information System (HMIS), identifying those who have spent one or more days in a homeless shelter in past 15 months; Department of Social Services (DSS), eligible for Medicaid; Department of Children and Families (DCF) involvement, Department of Mental Health and Addiction Services (DMHAS), Department of Correction (DOC), one day incarceration in past 3 years; and Court Support Services Division of the Judicial Branch (CSSD), those on probation or who have been in the court system.

iv. The data sharing and transfer process is being rigorously developed and reviewed across the state agency partners to ensure that it is HIPAA compliant and secure.

v. The master integrated data set will be a starting point to review for patterns and from which to make determinations of what criteria should be used to flag high need (high degree of system usage) for the different services represented in the match. All agencies that have contributed data will be part of that discussion and determination process.

1. One goal is to identify most intensive high-system utilizing households as a subset, in order to look for patterns and determine if there are upstream interventions to explore based on those patterns.
2. A second goal is to select two cohorts (individuals and families) from the 500 highest frequency user households for a pilot coordinated service provision exercise in Fairfield County. (Beacon and CHN will execute the outreach to eligible households to offer participation in the pilot program and to secure releases of information for those who want to participate in the care coordination offered.)

b. Scott Gaul, Chief State Data Officer, Office of Policy and Management.

i. The 500FF Data Match for the Task Force is a necessary and ambitious project. Agencies have been generous with time and expertise, many pieces are uncharted. It is helpful that many agencies have been involved. This project has provided an important focal point to help multiple partners think through concretely how to develop a solution for this particular case, along with two other important cases-in-point: integration of data for the state 2Gen and Workforce Councils.

ii. OPM submitted a report to the legislature regarding data sharing, including for the three test cases noted. The report enumerates certain barriers to data sharing and begins the next round of discussions regarding how to develop methods to facilitate these and future projects that require data sharing. (Report attached.)

c. Service Coordination, *Rick Porth, United Way of CT, and Fred Morton, DMHAS*

i. Lauren Zimmerman, Supportive Housing Works, presented on the pilot service delivery concept created by the Task Force subgroup. (Presentation attached.)

1. Goal is to engage 30 families and 30 individuals as client household. Those who agree to engage in the pilot will complete a priorities and values map developed in conjunction with the Yale Program on Recovery and Community Health (PRCH), Dr. Maria O'Connell and her team. The map is the centerpiece of the person-centered (and 2Gen) care approach that is at the core of the service delivery pilot. Drawing on successful use of this approach in more limited settings (including chronic health condition management and substance use recovery), the pilot will capitalize on the success of this approach by using it as the basis of multi-disciplinary care coordination.
2. A leadership group of senior agency/provider decisions makers will serve as the path-clearers for coordinated work; the group of people who have macro perspective, understand resources available, and can help to manage challenges and overcome obstacles.
3. Key Providers and Direct Care Staff: households engaged in the pilot will likely have a complex web of case managers, navigators, services, with which they have engaged. Consistent with person-centered care, clients will have the opportunity to designate a "Key Provider," from among these direct care staff. That person will be the identified as the chief advocate and partner for the client/client family, to walk alongside the household, and help to manage the web of care providers and services to achieve a coherent, effective whole service plan that advances the goals of the client/family (as articulated in the "map.")
4. Training and onboarding of the staff from state agencies and nonprofit providers engaged in the pilot will be central to the success of the work. Training will include Adverse Childhood Experiences (ACES); person-centered care; and Critical Time Intervention (CTI).
5.

ii. Rick Porth underscored the fact that the presentation on the service delivery concept represents hours and hours of careful strategic thinking by a wide range of partners from state agencies and nonprofits alike. HE noted, as well, that one important key to creating more effective service delivery for these households would be the opportunity to use more flexible, innovative service and supports. This includes "flex funds" that can be used to support the goals/priorities of each household, going beyond the constraints of traditional benefits (which do not always meet a household's specific needs). At the same time, flexibility for providers to think "outside the box" would be important – allowing them to work from the perspective of the client/family's goals and needs – rather than from the perspective of usual program constraints. Rick noted that there are numerous examples in CT and elsewhere of what can be achieved through this flexibility with regard to better human outcomes and saving of precious assistance resources.

IV. Next Steps and Discussion, *Lisa Tepper Bates and David Rich*

a. Key next step is to identify the central core of agencies that will be involved in the service delivery pilot, and who will be asked to identify senior points of contact who will serve as the core team.

b. Discussion of the training plan for the pilot will be moved to the next meeting of the Task Force.

V. Other Business – N/A.

VI. Adjournment – 12:00 p.m. Motion to adjourn approved unanimously.