CT Family First – Candidacy 2.0 Workgroup

Date of Convening: February 28, 2020

Agenda

- Welcome and Introductions
- Recap Candidacy 2.0 Overview and Associated Requirements
- Screening/Assessment/Eligibility Process
- Logistics
- Closing

Recap Candidacy 2.0 and Associated Requirements

- At this meeting, the Co-Leads invited people representing Voluntary Services (Beacon) and IFCS to present on current eligibility/assessment processes being used for those programs. The decision-making tools of these processes along with Structured Decision-making (SDM) used by Careline was discussed.

Careline SDM (Structured Decision Making) Tool and Differentiated Response System

- The SDM tool is meant to reduce harm and expedite care in order to help families. It is used to determine whether an allegation meets the definitions of abuse or neglect. Depending on the severity of the allegation, it may or may not meet the threshold. It also helps Careline workers decide whether something should move to the FAR (Family Assessment Response) or INV (Investigation) track.
- FAR tends to be a 72-hour response. This track is used for families where the allegation meets the threshold for abuse or neglect but there is low risk. The major difference between FAR and INV cases is that FAR cases are closed with no decision regarding a substantiation. If the family needs further support, families can be sent to CSFP (Community Supports for Families Program).
- All calls still go to the Careline; the Careline then uses this to determine whether an allegation meets the statutory definition, if so, they then determine the track and response time.
- One person wondered whether the Family First Assessment tool should be placed at the Careline; however, there was some concern that placing it there might make it too embedded in the DCF system. Also, wait times at the Careline are already quite long, and adding this as a step might worsen that issue. Overall, the group agreed that the Careline was probably not the best place to do the screening.
- There are several screening tools used throughout the DCF system. At the Careline, the SDM tool is used to determine whether an allegation meets statutory thresholds and if so, how fast DCF will respond. At Intake, there is an SDM Safety Assessment

Tool and an SDM Risk Assessment Tool. There is also the Family Protective Factors which assesses the family's strengths and needs.

- The group discussed what Family First might be able to leverage and expand for our purposes. The group agreed that from a resource standpoint, it makes sense to expand existing tools. However, we also hoped to build something that would exist outside of the DCF system.
- One person explained that it makes sense to want the same experience/feeling for families, regardless of what door they enter from. Even with that goal, it might make more sense to align two screening methods rather than create one entity to screen everyone, given that there are already screening methods in place.
- Another option is to create some sort of screening on an administrative level. Perhaps it would be possible to do some sort of data dump and not screen people directly; however, this affects timelines. This is something that we would need to discuss with IS staff to determine what would be possible.

Beacon: Voluntary Services

- Voluntary Services currently overseen by the Department, will be transitioned over to Beacon. The goal is to create more consistency and better meet family needs. The screening that Beacon uses is a level of care assessment. Hopefully, this will eliminate the need to call the Careline to access Voluntary Services.
- To be eligible, one must have a diagnosis of a mental health or substance use issue **or** a disability and a behavioral health issue. They must be willing to engage in services, and there needs to be a treatment plan in place. Youth are ineligible if they are juvenile justice (JJ)-involved, not cooperative, or DCF-involved.
- Anyone who is participating in Voluntary Services has a dedicated Care Manager.
- Currently there are about 100 people participating in Voluntary Services at any given time. We estimate that about 280 families/year will be served through this system. The Department does not anticipate any waitlists.
- Payment is done through insurance or Medicaid if that is an option.
- The group agreed that Voluntary Services has sometimes been difficult to navigate in the past, and it might be a bigger system once it is made easier for families.
- An interesting data point is that families of color are underrepresented in Voluntary Services. The need for cultural and linguistic competency was emphasized.
- One person wondered whether we might consider siblings of children in Voluntary Services as part of either of our definitions. This point was not discussed by the broader group.

- Referrals are made through an abbreviated referral form. The presenter was asked whether they saw any issue with flagging these for eligibility. They responded that it is possible, but it would really depend on what questions were asked.
- One member reiterated their hope that we could come up with one referral/screening process for all families. They also made the point that when doing referrals and screening, it would be helpful if a family could provide one form that covers all the children rather than having to fill out a separate form for each child, which is not a family-friendly method.

Beacon: Integrated Family Care and Support (IFCS)

- IFCS was created as a way to develop proactive service interventions for children with unsubstantiated reports and their families, decrease transfers to ongoing services, subsequent reports, and substantiations. It aims to increase the needs met and ensure racial proportionality amongst the families transferred to IFCS. It takes a wraparound philosophy and approach, utilizes warm hand-offs, and measures family satisfaction through surveys. IFCS roll-out has begun but it will not be complete until April 1, 2020.
- Currently, Beacon has two ways to connect: a call center and an online portal. There are certain requirements for referrals, but providers with good performance can bypass some of these requirements.
- There is a call center which operates from 9 am - 5 pm and an emergency line that is 24/7. There is no respite option.
- The group discussed some questions they had.
    - One person asked to clarify whether we are focusing on the narrow or broad in this discussion. The group was mainly focused on the narrow, but it would be conceivable for the group to come up with recommendations that could also apply to the broad.
    - The group had a brief conversation about Medicare and Medicaid. One person brought up the situation of families who need congregate care but have trouble getting it; they also wanted to know who decides what is Medicaid vs non-Medicaid. Miranda Lynch of Chapin Hall with the University of Chicago explained that every state decides its Medicaid plan (based on the law), and it is to the state's advantage to include more things. The Children's Bureau would not have access to Connecticut's Medicaid plan. One person pointed out that EPST is not in Connecticut's Medicaid plan. Furthermore, we should consider that there is both Husky A and Husky B, and many of the families we work with

are covered by Husky B which has a different level of services. Also, in-home services for youth with autism are not covered.

- It was also established that IICAPs is not an EBP on the Federal Clearinghouse.

211: Mobile Crisis Intervention Services and Other Services

- Mobile Crisis can be accessed through 211 or occasionally through a direct call to a Mobile Crisis provider.
- 211 gets many calls for many different things, including about 20,000 behavioral health concerns. About 5,000 calls do not reach Mobile Crisis because they are triaged out for information and referral to other services. Of the 15,000 remaining behavioral health calls, about 46% are from schools, 40% are from families, 10% are from hospital emergency departments, and 5% are from all other referral sources combined.
- 211 and Mobile Crisis providers do not screen out many requests for a behavioral health response. The only children ineligible for Mobile Crisis response are those in inpatient, residential, or subacute unit.
- 211 takes the person's basic information and location. They are then routed to a local agency. 211 information gathering takes around 3-5 minutes, then they are warm transferred to the local agency.
- The group agreed that the warm transfer was a good system, and they also appreciated the line has good hours.
- One person asked whether it would make sense to create a parent mobile crisis line, since that may be another highly risky pathway. In response, another member wondered if an adult/child crisis team would be beneficial to address both, since one would affect the other.
- So far, the discussion has focused a lot on screening and eligibility. The group pivoted to a discussion on how to connect the child and family to developing the child-specific plan that is needed. Where is that slotted in?
    - One possibility is through a Care Management Entity, but that still does not fully answer where you have the conversations and feed that information back to the Department.
    - The group also agreed that the hardest part would be to operationalize the 6th population group (community pathways) because that system does not currently exist.

Screening, Assessment, and Eligibility Processes

- The group discussed what design elements they would want to see. First and foremost, they agreed that the emphasis should be on the family, not the child. Obviously, the tracking needs to be child-specific, but it should serve the whole family. Ideally, the family should not feel like the child is the only focus. For example, Maryland's family service plan identifies the child(ren) at risk, but there is no other change.
- The group was informed that there is now an index of state plans for those states that have a plan submitted, under review, or pending.
- One person pointed out that in Pennsylvania, Family First considerations are added to a family's current plan when under the Department's purview. Given that populations 1-5 are already related to the Department, this person suggested also using a DCF-related mechanism for screening too. For efficiency's sake, it makes sense to work with the system we already have.
- This was a fair point, but this also means deviation from the start—families will therefore have a different experience based on what "bucket" they fall into.
- Another point was made about the concerns that this process could hold up the creation of the Prevention plan. It is important for us to decide on these measures, but it could be faster to base parts of these tools on what we already have rather than creating a new system.
- The group did a quick level set on what it is we are trying to work on. During the initial candidacy discussions, there was a lot of repetition of the "funnel" concept. The group needed to keep in mind that although some of the candidacy populations seem broad ("all accepted Careline calls," for example), being in the pool does not necessarily mean that one will receive services. First, a family would need to be screened as potentially needing Family First services, then assessed to determine their needs. There are also insurance questions, as Family First is the payer of last resort. The purpose of these discussions is to determine what infrastructure is needed.
- One person suggested the group consider the question, what are the values guiding our approach?
- Another person explained that they feel like we should be focusing on population 6 (community pathways), since they are the most tricky to capture.
- The group brainstormed who would be a referral point for families in this category. Pediatricians, early care/education professionals, etc. were considered, as was the possibility of families being able to refer themselves. These children are identified in

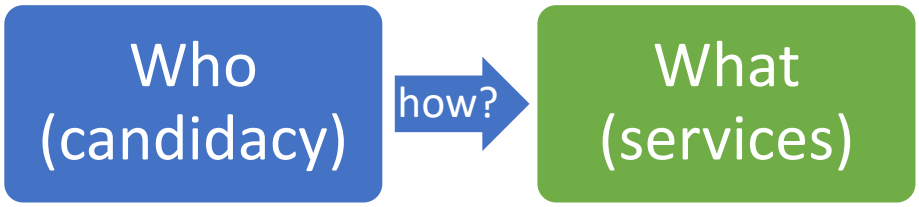
many places already, it is just a question of how to give those who can identify them the ability to make referrals.

- It was suggested that we consider creating one process but with multiple entities able to deliver the process. It might be a better option to have one route for DCF-involved families that is more integrated with the usual process and a separate route that utilizes the same tools and processes for families using the community pathways. Further, it might be too expensive to use just one entity, whereas integrating it somewhat into DCF's system would be more efficient.
- Many in the group agreed that it made sense to create some sort of portal that could act as a referral system. This way school social workers, pediatricians, community members, etc. could all use some kind of online method for referring families.
- The Co-Leads agreed that this would be a convenient option for many families; however, another part of the process is creating a way to monitor families' progress. How would an online portal translate into the necessary feedback loop?
- One person considered basing Family First eligibility around specific issues or situations, since not everyone in the bucket would need these services. What are the best questions/determinants of risk? How do we come up with these?
- As one member framed it, the biggest questions are 1) how do we know about population #6? And 2) How do we develop a screening and assessment process that identifies families' real needs?
- If creating an online portal, it was suggested that we look at the "Am I Eligible?" page that DSS ConnecT offers. This portal helps folks determine their eligibility for benefits like TANF and WIC. It is not the final screening process, but it is a kind of "pre-screening" so that those who come for screening are more likely to actually be eligible.
- Creating a portal is also a convenient way for those making the referrals to be updated on new developments.
- One person pointed out that we are aiming to serve a broad group of families and yet we are meant to asses which families are at imminent risk of foster care, which is rather narrow—how do we reconcile this?
- Another workgroup member suggested building off the screening tools used at Beacon for IICAPs. They use level of care guidelines and build off these screens to prevent a higher level of care.
- The representative from Beacon clarified that it is not Beacon who does the screening in these cases but an objective reviewer. The reviewer's process is meant to determine whether the symptoms match the level of care they are given. It is a good way to

prevent the need to get into a higher level of care. It might be possible to adapt this tool.

- In response, another person clarified that it is important not to scare families. It needs to be a careful process that does not even put the thought of removal on the table.
- One of the members who works for DCF IS mentioned a tool that was created for hospitals to gather information for the Careline. There was a portal to add information, analyze the initial screening, then determine funneling. The same issue that came up with the portal came up again here—what is the back end? How do we track performance over time with this method?
- JoShonda touched base with the group to make sure everyone was roughly on the same page with the suggestion. The group seemed to agree that the recommendation was to create an online tool that the community can utilize. This seems to be a solid starting point.
    - Another main point is that this works best when there is another human involved to do a warm hand-off. If we go with an online portal, there is a gap here, especially when families are referring themselves.
    - Another possibility would be to create a Care Management Entity--either a Warmline or a review portal that would do a more in-depth assessment. This entity would then be the connection to a service. This seems like it would fit both the narrow and the broad.
    - JoShonda gave space for reactions.
- The group pointed out that even if it is not DCF doing the warm hand-off or constituting the Care Management Entity, they still need to be involved somehow. DCF would have to be the sign-off, and there would need to be some kind of thread between the two.
- One person wondered what method would be best for care management of needs. Would it be best to have a central or regional Care Management Entity? Would it be possible to have both?
- Another info line brought up was the Help Me Grow/Child Info Line. There is a call-in number with a real person who helps talk things through.
- Another member felt that it should not necessarily be a one-size fits all situation. There is some utility to building it off of 211. 211 is an existing entity, and having folks call their line means we are basing it off an infrastructure that is in place. This would also situate the screening outside of the Department, which is one of the things the group has highlighted.
- Others agreed that a Family First Warmline or 211 would be great.

- One person felt confused because it seemed that the group wanted more services for more people, but this is not necessarily the goal of Family First. They felt that Family First should be more behind-the-scenes work. 211 might be a good starting point for referrals but not for the actual screening.
- Others in the group felt that there should not be just one path to services. There should be multiple baths that providers and parents are all able to use.
- Clarification was needed as one person felt that developing the needs assessment was not really part of the Candidacy workgroup's responsibilities. JoShonda explained that we have already determined the **who** and Programs and Services is working on the **what** (the services that we will provide). Right now, we need to focus on the **how**. How do those people who are part of the candidacy definition get funneled to the services?



- One person explained that they felt a portal would be a benefit because it helps identify initial need and connect someone to a possible service. Administrative mining could be used to do the actual screening.
- Another benefit of a portal would be to identify gaps. If there is a lot of need for a service we do not offer, it could be a good source of data on what programs are still needed.
- At this point, the Co-Leads felt it would be best to pause, share these preliminary recommendations with the Governance Committee, get feedback, and determine whether there are any procurement issues. They did not want to go too far in the design process if there could be conflicts of interest. In that case, we would cancel the meeting scheduled for March 9th and reconvene on March 23rd.
- As far as candidates 1-5 (who are all touching DCF in some way or another), the group seemed to agree that it would be best to have a separate path that is more connected to DCF. There are tools and approaches already in place--it seems like the social worker should be the one who utilizes this process.
- One DCF worker pointed out that DCF has FSN every six months. There are also many screening tools that work for families that could be recommended. Maybe a group of

DCF staff could come up with a tool based on these existing tools and then bring this to the group for community feedback.

- The group agreed that DCF ought to determine what that tool might look like and where in the case plan it would go. The Candidacy workgroup would still get to provide feedback and decide whether to recommend that tool.
- Jeff Vanderploeg felt that one thing the Community Partnership workgroup should give feedback on is providing family-friendly messaging. Others in the workgroup agreed, and it was also suggested that family input is solicited on the specific questions and framing that are used.
- A workgroup member brought up New Jersey, which is trying to look at data on non-accepted calls to develop a Warmline (situated somewhere between 211 and the Careline). They want to look at this data to bring partners to the table.
- Another topic for discussion brought up was the issue of senior housing--grandparents can be a good placement resource, but their housing may have restrictions on who can live with them; this makes it impossible to place kids with people who would otherwise be a good resource.

Next Meeting

- The meeting scheduled for March 9 is **cancelled.** A cancellation notice was sent out.
- The group will reconvene on **March 23** after the Governance Committee has a chance to review the preliminary recommendations. The meeting will take place from **1 - 4 pm, location TBD.** *Note: This meeting has since been **cancelled due to the COVID-19 outbreak.** Please keep checking the DCF Family First website for the most up-to-date schedule. Thank you.*
- If anyone has questions or concerns, please reach out at dcfctfamilyfirst@ct.gov