Meeting Summary/Minutes
Family First | Fiscal and Revenue Enhancement Workgroup
March 12, 2021 | 1:30 - 3:00 pm | MS Teams Meeting

Welcome and Introduction

- The co-leads for the workgroup, Cindy Butterfield and Allison Blake, thanked workgroup members for attending.
- Desired results:
  - Obtain a shared understanding of the last revisions to the cost benefit analysis
  - Acquire last input from the workgroup
  - Validation of the process leading to recommendations for Governance
- Based on the input from the last meeting (3/4) and collaboration with the co-leads of the Programs and Service Array Workgroup (PSAWG), a two-fold presentation has been organized. This presentation will be presented to the Governance Committee on 3/16. All EBPs will be compared across 1) fiscal criteria and 2) programmatic criteria (slide 4).
- The cost benefit analysis has been revised to include information on the cost of BSFT, Connecticut-specific data on FFT and MST, revised costs per family for early childhood services and the cost benefit analysis for those services, and Connecticut dosage duration data for early childhood series.

Selected Evidence-Based Programs

- Cindy thanked the workgroup for their feedback from last week; she felt that this made the analysis more accurate with better data. She reviewed the analytical process and the variables that went into the analysis (slide 8). Cindy and Allison went through the EBPs (slides 9-18). To view the data and analysis, please see the 3/12 presentation. Questions and discussion points are listed below by EBP.

Healthy Families America (HFA)

- One person asked about the percentages listed on the slide (break-even). Cindy explained that this is calculated using the average cost of being on the caseload/in foster care. The percentage listed is the percentage that would need to be diverted from the caseload/foster care to break even. Some families may have multiple children, meaning that more children would be diverted without raising the cost - 45% of children in DCF care are in sibling groups.
- A member mentioned that OEC may be including HFA in their RFP, but it is not clear where they are in that process.
- One person raised the idea that this analysis seems to assume that the children and families who engage with the service are likely to go to the DCF caseload or into foster care - they are unsure about this assumption. Cindy acknowledged that the analysis is somewhat imperfect.

- The effectiveness with child welfare population is not always tested. Some of these programs are well-suited for DCF-involved families, whereas others do not have the data yet.

Nurse Family Partnership (NFP)

- No comments

Parents as Teachers (PAT)

- A member raised the fact that the CT Dosage Duration is 13 months; they were unsure whether the outcomes are achievable in that length of stay. Cindy agreed to reach out to OEC to double check this. The length listed on the slide is the stay in CT, but she is not sure how that compares to the model developer's optimum length of stay. She will do more digging.
- The member reiterated that it is important to look at the population served by the program (and their respective risk level) as well as the outcome data's relation to service length.

Parent Child Interaction Therapy (PCIT)

- A workgroup member did not feel the cost was correct; there is an elaborate set-up with mirrors, etc. Staffing costs should be higher. Cindy agreed to double check the cost but was fairly certain these costs are all included.

Functional Family Therapy (FFT)

- Connecticut data is available for FFT that shows the difference in outcomes between those who completed and did not complete the program.

Multisystemic Therapy (MST)

- Connecticut data is available for MST that shows the outcome measures in Connecticut vs nationwide from 2016-2020.
- The group liked the way the data was displayed. It included information about children remaining in home, in school, and did not get arrested, which the group felt displayed the prevention possibilities beyond child welfare (e.g. preventing incarceration).
- One person wondered whether MST was cut at all, since the numbers look lower. Cindy explained that we used to contract directly but no longer do, so that might be part of why the numbers are reduced. It may also be related to the pandemic.

Brief Strategic Family Therapy (BSFT)

- The cost is from another state, so Cindy agreed to investigate further.

Motivational Interviewing (MI)

- No comments

Comparison Between Similar EBPs

- Similar EBPs were grouped together based on similarities (slide 19). The groupings were:
  - HFA, NFA, and PAT
  - FFT, MST, and BSFT

Discussion

- One person recommended we consider how prepared Connecticut is to meet workforce development needs and factor this into our analysis? For example, HFA does not require the provider to be a clinician, whereas other models do, meaning it may be more feasible. Others in the workgroup echoed this suggestion.
- A question was whether it is better to have a high or low breakeven percentage. Cindy explained that a low breakeven means that it is easier to recoup the costs of the initial investment, making it cost beneficial; however, it is not all about cost. Really effective programs may cost more, so that is not the sole deciding factor. Others in the workgroup agreed that a high cost program may be worth it.
- A member asked what the requirements are as far as tracking outcomes and effectiveness. Olivia Wilks, Chapin Hall, explained that there is a CQI component, but the mechanisms are still being developed and will depend on the EBPs.
- Some folks were unsure about PCIT as a model. There have been some concerns about it. One member shared that they had proposed it and CPP for a grant and ultimately decided to choose CPP because of the existing research and the fact that there is a lot of attachment work done already.
- Another member added that PCIT has potential, but they were concerned that the requirements are too challenging. Although it might be effective, the costs may be high. Cindy agreed to double check the budget for this one but felt that it does become low cost because of the high volume of people it serves. A member added that they are a trainer in PCIT; the training is about $1,700 and the train the trainer training is about $4,000.
- Cindy confirmed that all the costs listed included start-up costs, except for BSFT, which they could not find cost data for.
- One person reiterated that it is important to look at the population served by the program and their risk of child welfare/foster care involvement. The actual effectiveness depends a lot on the population. It could be possible to end up with a cost-effective program that does not impact much. They wanted a robust array that includes both low and high-risk youth.
- A workgroup member encouraged the group to think about prevention in terms of Connecticut kids, not DCF kids. We need to show that we are supporting these programs through all sorts of funding and create a whole network of funding. They did not feel like we are currently doing this. Cindy agreed that this is an important point to consider when

matching the candidacy pool with services. None of this work is separate from the other work happening in the state. She affirmed that they will consult with OEC to consider what is in place and could be leveraged. JoShonda added that along those lines, we cannot lose sight of the broader plan.

- Cindy was asked whether fiscal will repeat this process with the Tier 2 services that PSAWG looked at. Cindy explained that we are starting with Tier 1 for the initial plan but we will continue moving forward to analyze the Tier 2 services.
- Given that reimbursement is only up to 50%, one person asked how big an investment CT is willing to make. Cindy said that they did try to size entry points and candidacy, but it was fairly challenging given how broad the definition is. Decisions do need to go through the Governance Committee and OPM, and they may scale. The legislature seems very open if there is a good cost benefit and proof of concept; however, overall it is unclear (especially with COVID). We will need to put in budget options through OPM and the legislature.
- A workgroup member indicated they hoped we would take this in steps and learn over time; we do not want to take away from something else. Cindy confirmed we are moving in stages. Tier 2 and Tier 3 are part of the process too, and they will not be left behind.
- There was a question on Title IV-E being the payer of last resort and whether this also applies to MIECHV funding (that MIECHV would pay first). Cindy believed that Title IV-E is the payer of last resort in all cases but will double check on this.
- One person asked whether there will be different tiers of kids for program implementation. JoShonda said that we had not planned on segmenting the candidates but perhaps with more context, we could consider what that might look like. She offered to discuss offline.

Next Steps

- Follow-up:
  - Look at risk level and program success by risk (including child welfare risk)
  - Double check start-up costs for certain programs
- 3/16 - Governance Committee meeting
- The next Fiscal workgroup meeting will be **1:30 - 3:00 pm on Tuesday, March 30**.
- Cindy and Allison thanked the workgroup for making the time to attend and participate. We appreciate everyone's contributions.
- Allison also thanked Cindy and DCF's fiscal team for their work on the analysis, especially during the legislative session and with a short turnaround time.