# CT Family First - Governance Committee

March 16, 2021 | 8:30 - 10:00 am
Microsoft Teams Meeting

**Welcome and Introductions**

- The Commissioner welcomed the members of the Governance Committee and reflected on what has changed and what we have lost in the past year. Prevention will speak to families and help them thrive. We have had over 400 partners helping us in our upstream efforts, and they have taught us more about our communities.
- In April, the rough draft of the Prevention Plan will be sent out to the Governance Committee, and there will be a 2-week public comment period. DCF hopes to submit the final document to the federal government in early May; however, this is an iterative process, and we will revise as we go.
- Desired outcomes:
  - Review fiscal and programmatic criteria for EBPs
  - Make recommendations to the Commissioner for the CT Prevention Plan
- Committee members were tasked with asking questions and offering feedback on the recommendations.

**Review of Evidence-Based Practices (EBPs)**

- EBPs were analyzed from both a programmatic and fiscal perspective. Based on that analysis, they were broken down into three categories based on who they are meant to serve: 1) children and adolescents with identified treatment needs; 2) adults with identified treatment needs; and 3) adults with parenting needs. Models were reviewed based on which section they were in. For the full analysis of the EBPs, please refer to the 3/16 Governance Presentation.

***EBPs for Children and Adolescents with Identified Treatment Needs***

- Models reviewed in this category:
  - PCIT
  - MST
  - BSFT
  - MDFT
  - FFT
  - TF-CBT
- Programs in this category are shown in the chart (slide 5) that shows the intended age range, description, number of candidacy groups matched for needs, and top three outcomes. More information about the models was discussed below.
- PCIT is in an RFP with the Office of Early Childhood (OEC). This service could be introduced as a new service as a placeholder for a younger age range.
  - An OEC participant specified that this is an active RFP for all home visiting EBPs. There has been some advocacy regarding particular models/concerns, but

OEC is working to address those concerns and fairly consider all models. They are excited to continue breaking down silos.

  - Elisabeth Cannata explained that PCIT is listed in this section because the entry point for the program is the child, not the parent.

- BSFT does not currently exist in CT. It also overlaps with other models and would involve an added cost to introduce it to the state.
- The presenters displayed a chart that shows more information about the EBPs, including duration, intensity, service location, and provider credentials (slide 6).
- It is important to consider these factors because they affect the cost (e.g. a higher intensity model will likely have higher costs).
- One person asked whether workforce considerations went into the analysis, and Elizabeth Duryea explained that neither PSAWG nor Fiscal specifically analyzed this issue in depth, however, there was some general discussion where the model requirements for program teams can create implementation challenges. One member referenced an evidence-based initiative that did not have enough Spanish-speaking workers to meet the needs of the Latinx population; Elizabeth confirmed this is a challenge for our system.
- PSAWG did look to only forward for consideration models that had evidence of having been researched with communities of color, but that does not necessarily equate to an in-depth analysis of comparative outcomes by race/ethnicity within those studies (this would require more in-depth review of methodology, sample sizes, etc. to determine what level of conclusions could be made with regard to relative effectiveness. Language capacity is an issue beyond EBP effectiveness that also needs to be addressed.
- The Fiscal comparison of the EBPs included the cost per slot, alternative funding streams, and cost-benefit - how many children would need to be diverted from the caseload or from foster care to make the service cost-beneficial (slide 8).
  - Cindy Butterfield noted that start-up costs are not included for many of the programs, since they are already in place.
  - This analysis focuses on the short-term prevention of DCF involvement.
- The presenters addressed a question regarding CSSD providing MST. DCF will be purchasing their slots, and there will also be conversations with them about what they could use - another layer of sizing.
- The group was glad to hear about the coordination. One person asked whether incarceration is included as a possible diversion. Cindy acknowledged that these programs will likely have further positive impacts downstream like diversion from juvenile justice involvement and incarceration, as well as things like educational achievement and homelessness prevention; however, when sharing this plan, our best argument is the immediate savings. The other diversions will not be the focus, but we do agree that diversion goes beyond DCF.

***EBPs for Adults with Identified Treatment Needs***

- Models reviewed in this category (slides 11-15):
  - MI
  - MMT
- MI (Motivational Interviewing) is a strategy that has only been reviewed on the Clearinghouse for substance use treatment. The reimbursement would cover the training in MI. Elisabeth added that it can also be applied to QA, ongoing learning, etc.
- MMT (Methadone Maintenance Treatment) specifically is on the federal Clearinghouse - other medication-assisted treatments are not included.
- We are currently getting 75% reimbursement on our MI training.
- MMT is listed as matching with three candidacy populations: 1) parents with substance use issues; 2) accepted Careline calls; and 3) substance-exposed infants. Those may not necessarily be identified by the Department; parents with substance use issues and substance-exposed infants could come through a community pathway.
- JoShonda explained that based on the programmatic and fiscal analysis, these two programs are not recommended for the plan; MMT could be picked up in a future state, but it does not align with the fiscal opportunity.
- Elizabeth reminded the members that this is an iterative process. PSAWG is excited to move beyond the limitations of Tier 1 and Tier 2 services, recognizing the strength of additional programs in CT's strengths that are categorized as Tier 3 or below.
- Some general thoughts were shared about the programs presented so far.
  - PCIT does not currently exist and is relatively low cost.
  - JoShonda said they initially thought highly of PCIT, but some providers were unsure. Cindy followed up that the providers thought the costs were higher than they actually are. There are some requirements regarding the setting, but she has reviewed and rechecked the costs, and even at the top of the scale, it would be only slightly higher per slot than the current analysis.
  - Elisabeth added that PCIT targets early childhood and we would also want to consider other early childhood models.
  - Cindy feels that neither MI nor MMT should be included, given that MI is already reimbursed at 75% and MMT is covered by Medicaid.

***EBPs for Adults with Parenting Needs***

- Models reviewed in this category (slides 17-21):
  - HFA
  - NFP
  - PAT
  - Triple P
- These models target different age groups; there is a lot of overlap with OEC. MIECHV currently pays for HFA, NFP, and PAT. DCF, OEC, and a Maintenance of Effort (MOE) expert are exploring the possibility of claiming for QI/QA and/or startup costs.

- One person asked whether DCF is solely funding Triple P. Cindy said yes, and she will double check on this. Elisabeth said that Triple P is part of the Parenting Support Services (PSS) which also includes Circle of Security.
    - Circle of Security is in the queue for the Clearinghouse.
    - It is possible to get Triple P without a DCF connection.
    - JoShonda explained that if the infrastructure is built out, if a child is a candidate in a family with an identified need, we would be able to claim.
    - The models funded by other methods are being highlighted - there may be parallel infrastructure that could be built out.
- In terms of the fiscal analysis, the Commissioner reminded the Committee of Title IV-E vs the broader prevention plan. We need to ask where we see ourselves in that broader context and think about how we are supporting families. CT is a small but diverse state, and Family First cannot accomplish everything we want to accomplish on its own.
- There are many models for children ages 9-18, but most children involved with DCF are under age five. We need to think about the alignment with other systems.
- It was clarified that along with the four programs listed on the slide, a fifth program was also reviewed but not moved forward for consideration. Other programs in this category have been added since the initial analysis, but they have not been fully reviewed yet.
- Jodi Hill-Lilly stated that we need to think about prevention as a whole and do what makes sense for CT. Title IV-E is not our only reimbursement source.
- A workgroup member underscored this comment by highlighting the importance of aligning with OEC and Medicaid in the infant mental health field.
- One person asked whether Child First is on the Clearinghouse; JoShonda replied that it is in the queue, but it is unclear when it will be reviewed.
- A member wondered whether DSS has been thinking about amending Medicaid to include infant mental health services. In terms of next steps, they considered whether it would be possible to enhance or couple parenting support with adult mental health services. JoShonda was unsure if intertwining services has been considered in that way.
- Circle of Security has not been reviewed yet by PSAWG and Fiscal due to its level of support on the Clearinghouse.

**Model Review and Recommendations**

- The four services just discussed - **HFA, NFP, PAT, Triple P** - were considered.
- Putting a model into the plan does not mean that we need to do it or claim for it.
- Michael Williams suggested that all four be included. The Committee agreed.
- Elizabeth reminded the group that there is room for revision in future iterations; we recognize the principle of "do no harm" and want to make sure we are not doing anything that might impact existing services that currently serve many of our candidacy group

population needs. Some of these models are well established in CT are not on the Clearinghouse.

- The Committee considered **MI and MMT**.
- MI is not reimbursable as-is due to its delivery, and Cindy did not feel there is an opportunity to use it for contracted providers, although eventually it might be possible to flip down administrative costs. She did not see an opportunity to claim on MMT.
- One person asked whether FBR is being considered. Elizabeth answered that it is not on the Clearinghouse or currently in the queue, but it may be reviewed at some point given the evaluations underway for FBR
- A member pointed out that a lot of grant money has been invested in this population and inquired whether there were other EBPs for this population. Elisabeth replied that there is, but it is low on the Clearinghouse. There is also one model for adults with mental health issues, but it is only performed by a few providers and is reimbursable by Medicaid. It has been mapped to two groups. It will be considered for a deeper review.
- The Governance Committee decided not to include MI or MMT, although they did request further analysis about opportunities with MI.
- The Committee considered **PCIT, MST, BSFT, MDFT, FFT, and TF-CBT.**
- BSFIT overlaps with several age groups and overlaps in intensity.
- The versions of FFT that are approved are for external behaviors or substance use, not the adaptation for child welfare.
- Members felt it was hard to eliminate any programs when we are unsure of whether a treatment may meet the needs of specific communities of color. Although the research broadly includes communities of color, programs may be highly beneficial to a certain community - we should not eliminate any models that could fit this.
- In the interest of weaving equity and disparity data throughout the decision-making, all six models were approved for inclusion in the plan.
- Recap:
    - Governance **approved** HFA, NFP, PAT, Triple P, PCIT, MST, BSFT, MDFT, FFT, and TF-CBPT for inclusion in the first plan submission.
    - Governance **did not approve** MI or MMT for inclusion.

**Next Steps**

- The plan will be written, and CQI work will be added to the plan.
- Tier 2 services will be further refined.
- A Family First Director has been chosen and she will start soon.
- There is still much work to be done, but DCF appreciates everyone's contributions and dedication to this work.