FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
MYFLFAMILIES.COM

Office of CBC and ME Financial Accountability

CBC Financial Viability Effective Practices

Family Support Services of North Florida:
Providing intensive family preservation services within the home setting

11-13-2017

CBC Contact:
Larry West Jr., Vice President of Case Management
Family Support Service of North Florida
Larry.West@fssnf.org
(904)265-8106

Contents

Practice Summary....2
CBC Context....2
Practice Detail....2
Core elements....2
Barriers encountered and methods to address....4
Resources used to implement....4
Staff Feedback....5
Practice Example....5
Results....7

Authors

Family Support Services of North Florida

Lee Kaywork
Bob Miller
Larry West Jr.
Chris Compton
Chuck Young
Stacey West
Sarah Markman
Gwen Tennant-Evans
Carlos Cruz

Jewish Family Community Services (CMO)

Stephanie Metzger
Jennifer Wirz

DCF Northeast Region

Patricia Medlock
Billy Kent
Linda Compton
Dionne Danner

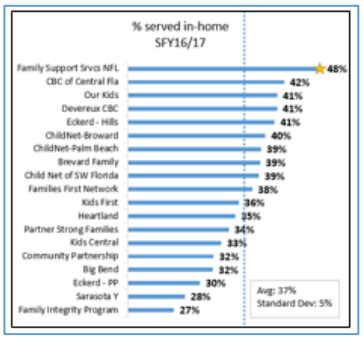
DCF Headquarters

Barney Ray
Marci Kirkland
Marissa Davis

Practice Summary

Statewide, the general practice for in-home case management is to refer families to services provided outside of the home (e.g., to appointments in an office or a classroom). Family Support Services of North Florida (FSSNF) has transitioned from this service referral model to a service delivery model that directly provides the majority of services within the family's home by a wrap-around team of professionals. Only a subset of cases (est. 20% or fewer) require a referral to a community provider for more specialized services such substance abuse treatment. Since the implementation of this program (called "FAST"), FSSNF has seen a sustained increase in the percent of children served in home, a sustained reduction in removal rates, and a sustained reduction in their out-of-home population. In SFY16/17 more than 60% of cases with a safety determination of "unsafe" were served in-home rather than out-of-home (for more detail, see "Results"). [1]

In SFY16/17, FSSNF served 48% of children in their system of care in-home; 2 standard deviations above the statewide mean



CBC Context

FSSNF serves two counties in the Northeast Region; Duval, an urban county with approximately 930K residents, and Nassau, a rural county with approximately 79K residents.

All in-home cases in both counties are served under the same home-based service delivery model. For SFY16/17 in Duval, 1601 children were served in-home by 30 in-home case managers.[2] In Nassau, 138 children were served in-home by 3 in-home case managers.[3]

Practice Detail

This section contains three parts; a description of the core elements of the practice, a description of barriers encountered and ways they are addressed, and the resources used to implement the practice.

Core elements

1. A core wrap-around team of professionals is assigned to each family to provide their in-home services. The in-home case manager is a certified case manager, enabling them to continually evaluate safety, maintain dynamic safety plans, and directly provide services to caregivers and children within the home setting. Each unit of five case managers has both an assigned therapist who provides therapeutic services within the home and a Family Intervention Specialist (FIS) who provides substance abuse assessments and some treatments within the home. Each CMO also has access to a health-care coordination FSSNF staff-person (accessed by a no-waitlist referral process).

[1] This home-based care is also available for children under a safety plan in a relative or non-relative placement.
[2] For SFY16/17 in Duval, an average of 735 children were served in-home and 788 in out-of-home each month. (CW Dashboard)
[3] For SFY16/17 in Nassau, an average of 65 children were served in-home and 81 in out-of-home each month. (CW Dashboard)

Services provided within the home setting:	*Resources*
Parenting	*Nurturing Parenting training*
Behavior Modification	*Behavior Modification training*
Ages and Stages Questionnaire	*Free training (assessment generates free community referrals)*
Budgeting	*Free training to case managers*
Therapy	*Contracted CMO staff therapists assigned to units*
Health-care coordination	*FSSNF staff health-care coordinators are available to all units*
Project Healthy Homes	*Intensive SAMH services delivered by SAMH provider network*
Family Intervention Services	*Substance abuse assessments and treatment services delivered within the home (with some more intensive treatments referred out to other services).*
Family Intensive Treatment Teams	*FITT is a DCF-funded program with contracted staff provided by the ME. Teams are composed of a co-occurring therapist, case manager, and peer support.*

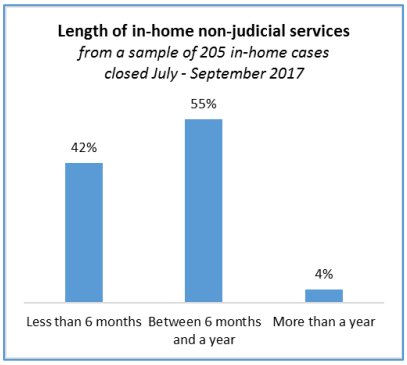
Outside services provided by referral include:

Services provided outside the home	*Resources*
Substance Misuse Treatment	*Income-based sliding scale*
Domestic Violence Services	*Free at local domestic violence center*
Domestic Violence Service Advocacy	*FSSNF has contracted for a DV advocate just for in-home cases. The advocate provides services at neutral locations.*
Homeless Temporary Housing	*FSSNF has contracted rooms at a local homeless shelter*
Human Trafficking Service Coordination	*FSSNF pays safe harbor rate for placements (uses 100/806 funds when applicable)*
Batterers Intervention Program	*Approx. $9 per session at a community provider (such as Salvation Army)*
Psychological Evaluations	*Varies per doctor's fee*

2. Practices are in place to ensure client access to and awareness of services. If possible, the in-home case manager provides transportation to services provided out of the home; otherwise they provide bus passes and then follow-up to ensure the services were provided. FSSNF provides a comprehensive community resource directory to its case management organizations with updates sent each quarter.
3. Standard processes are in place to engage the parents and increase their degree of accountability. Parents or caregivers sign an agreement at the initiation of on-going in-home services that acknowledges their responsibilities after extensive conversation with the case manager. The case manager references to this agreement as necessary to remind caregivers of their expectations.
4. An approach to safety management anticipates the potential of a case transferring to case management and enables a smooth transition for the family. In-home case management staff fill the safety management function where required for investigations, making a joint visit with the CPI within 24 hours of referral (or at discretion of the CPI)[4]. If the CPI determines that the safety of the child can be effectively managed in the home and transitions the case into ongoing in-home treatment services, the same case manager remains with the family to ensure continuity of care.

[4] Safety Management can be available within 2 hours if necessary.

5. Standards are in place to ensure manageable workloads for case managers: Each in-home case manager carries a maximum caseload of 20 children for on-going services and up to two Safety Management cases. They do not carry out-of-home cases. The average in-home case lasts between 6 and 8 months. Cases exceeding 12 months are rare and typically relate to substance abuse or human trafficking. The unit supervisor reviews safety plans biweekly and cases monthly (or at critical junctures). As of this report, there are no capacity issues or wait times for in-home services.



Barriers encountered and methods to address

Barriers encountered	Addressed by:
Some clients do not engage in services	The original CPI will return with the case manager for a joint home-visit to assist with re-engagement.
Some clients could feel overwhelmed by the variety of people in their home	"Warm hand-off" protocol: The case manager completes all initial joint visits with other in-home providers and the family to ensure that there is a "success bridge" built between the family and all the professionals that enter their home.
Issues of scheduling and communication between DCF and the CBC	Case management and protective investigative staff were moved to work in co-located offices.
	Monthly sharing of success stories: CMOs send "success stories" to CPIs with pictures of children who have been safely served in-home. Helps to "close the loop" for investigators and promote confidence in in-home services.
Issues of case progression/ resolving the present danger threats	Monthly internal team staffing of open cases at the co-located offices: in-home case managers, their supervisors, and any other service providers discuss identified families' safety plans, danger threats, behavior changes, conditions for return, etc. Ideas are shared to eliminate barriers and determine next steps. Any cases can be scheduled, but all are staffed at 5, 8, 11, and 12+ month intervals.
Issues of program consistency between CMOs and units	Establishment of an oversight coordinator: FSSNF staff position that provides quality assurance oversight and training. Facilitates program coordination/problem solving between parties.
Issues of caseload coordination between CMOs and services	Establishment of a centralized intake specialist: FSSNF staff position that reviews and assigns all incoming service referrals. Ensures equitable balance of CMO active caseloads.
Issues of communication and collaboration within the System of Care	Bi-weekly "Barrier Breakers" meetings: Leadership from FSSNF, DCF, the ME, the CMOs and other service providers meet to discuss resolve issues within their system of care. Also used to develop joint communications and messaging, negotiate service rates, etc.

Resources used to implement

FSSNF contracts for in-home case management by "business unit." One business unit funds 15 certified in-home case manager FTEs and 3 supervisors, as well as ten support workers, an associate director, and part of a director position. One business unit can serve approximately 450 children annually at a cost of $1.425M. The

CMOs determine staff salaries and how to best allocate the support positions. In-home case worker salaries range from $30-40K depending on certification and experience.

Additionally, FSSNF incurs annual program oversight costs totaling $520,746 that include the allocation of salary and benefits for the Vice President of Case Management, the Director of Family Preservation, three Oversight Coordinators, and three Community Resource Specialists. Other overhead (for rent, supplies, software, insurance, professional fees, etc.) totals $31K annually.

Staff Feedback

Feedback supports that this approach has proven effective and is the preferred approach by staff. CPIs and case management staff report that the wraparound in-home service model effectively engages families and successfully improves the conditions that resulted in the abuse or neglect report.

CMO feedback: "It's one-on-one engagement. Because the services are in the home, our staff are truly able to assess the physical environment and the ways that the family interacts. I believe this is the model for behavioral health integration; we're not sending them out to therapy, we're bringing it to them. Our case managers are doing true social work and they see every day the ways that they are helping families." (Stephanie Metzger, In-home Case Management Supervisor, Jewish Family and Community Services)

CPI feedback: "I am confident that when we refer a family to ongoing in-home services, they will be provided with the appropriate services based on that family's needs that will enhance caregiver protective capacities to keep children safe." (Dionne Danner, Family Safety and Preservation Services Program Administrator, DCF NER)

Statement from CBC leadership: "It is critical that as leaders we do everything in our power to allow a child to remain safely in their home. There is nothing as traumatic to a child as being separated from their parent. We have a responsibility to the children we serve to preserve the family unit whenever possible. We must give the Child Protective Investigators viable alternatives to removal." (Lee Kaywork, CEO, FSSNF)

Practice Example

Renee is a 17-year-old female who had been hospitalized for unmanaged Type 2 diabetes. She was not doing blood sugar checks, managing her diet, taking medications, or attending medical appointments. She had lost her mother to complications from diabetes but did not understand the harmful effects of not managing her condition. The child did not have a legal guardian and was living with a relative.

An initial joint visit between the CPI and the in-home case manager was completed on April 25 during the safety management phase (eight days after report intake). The child was determined to be "unsafe" by the CPI for reasons of medical neglect and was referred in early June to ongoing home-based in-home services.

The case manager determined after several visits with the child that she was not engaging in the recommended services (in-home therapy and health-care coordination for appointments and diabetes education). To re-engage the child, the case manager held two joint home visits in mid-July; one with the original CPI and their supervisor (calling the diabetes medical office with the child present), and the other with the therapist and health-care coordinator nurse.

After these joint visits, each time the case manager, therapist, and health-care coordinator were present at the home on their weekly visits, they would have the child check her blood sugar levels and then notify the other parties. The case manager would upload the meter readings into FSFN after each visit for the health-care coordinator to review. The case manager, therapist, and health-care coordinator would also share "ad-hoc" successes and updates with one another while interacting at their co-located office space. The relative that the child was living with served as a safety manager, also helping her monitor her blood sugar levels and navigate the medical system.

When the child saw a team of people working diligently over time to ensure her welfare, she began to understand the criticality of her condition. She began to attend medical appointments, check her blood sugar, and refill her own medications. Her last medical appointment showed that she had lost weight and her A1C levels were within normal limits.

This section intentionally left blank

Results

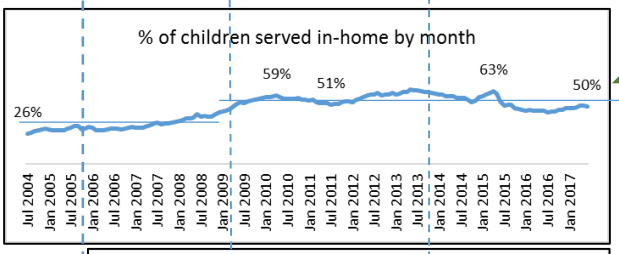
Primary benefits: **62% (1251 of 2011) children determined as "unsafe" by the CPI in SFY16/17 were transferred to ongoing in-home case management rather than removed from the home.** Of these, 90% (1129 of 1251) continued to remain safely in the home (i.e., they were not later removed from those in-home services).

Since the implementation of this program, FSSNF has seen a measurable and substantial increase in the percent of children served in-home (rather than removed), which is mirrored in a decrease in numbers of children in out-of-home care and a decrease in payments for licensed care placements. A common conception is that the degree of services necessary to keep children safely in their homes costs more than removing children from the home. However, FSSNF financial results indicate that the opposite is true.

SFY2005/2006: *Duval County implements new intensive in-home family preservation services for safe, but high very-high risk families.*

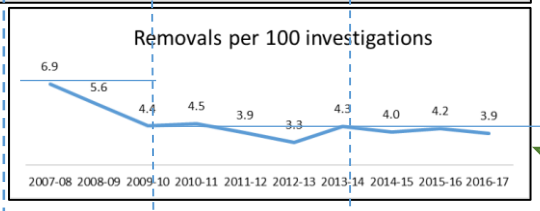
SFY2008/2009: *Nassau County implements intensive in-home family preservation services for safe, but high or very-high risk families.*
Duval County implements new enhanced, intensive in-home voluntary program for unsafe children (following the implementation of an comprehensive communication plan to all stakeholders: CBC, DCF, CMO, community partners, and the public).

SFY2013/2014: Nassau County implements new enhanced, intensive in-home voluntary program for unsafe children.



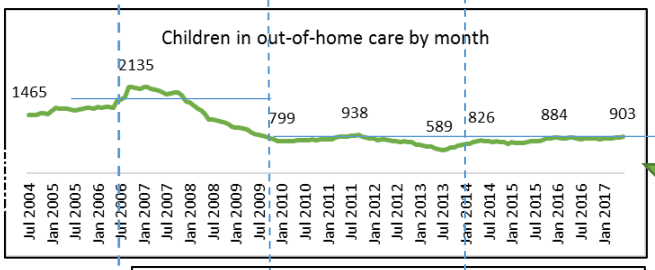
Good

Prior to January 2009, the average percent served in home was 33%. The average for the years following Duval implementation is 55%; an **increase of 22 percentage points**.



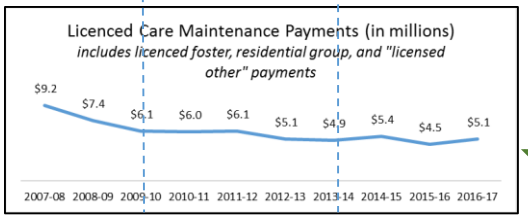
Good

The average annual removal rate per 100 investigations prior to January 2009 was **6.3**. The average for the years following Duval implementation is **4.1**.



Good

The average monthly out-of-home care prior to January 2009 was 1,691. The average for the years following Duval implementation is 827; **864 fewer each month.**



Good

The average annual licensed care room and board prior to SFY08/09 was $8.3M. The average for the years following Duval implementation is $5.4M; **a reduction of $35%**

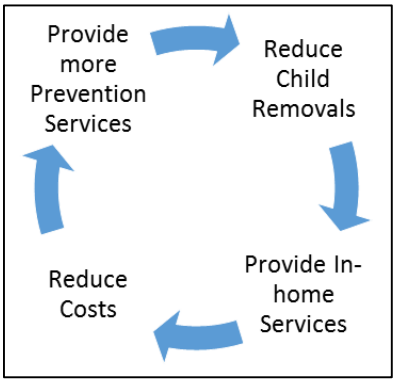
Since SFY08/09, FSSNF has averaged an annual carry-forward balance of $2.25M. They have never applied for Risk Pool funding.

Secondary benefits: An additional benefit realized by the team approach to care has been a decrease in workforce turnover. In particular, case workers who staff and manage out-of-home cases turn over at an approximate rate of 45%, whereas those managing in-home cases within an experienced wrap-around team turn over at a rate of 15%.

Cost savings with the approach used by FSSFN have been used to expand front-end prevention services to those within the child welfare system and to the community at-large. Below is a list and description of prevention services provided by FSSFN.:

1. *A 90-120 day prevention program for safe children with a varying level of risk for re-abuse. Co-located staff provide in-home services that include evidence based parenting, behavior modification, budgeting, connection to community resources, and case management.*

2. *A therapeutic in-home infant mental health program. The service provides in-home behavioral health and social services to children 0-5 years of age and their caregivers. High-Risk Newborn (HRN) serves young children who may be at risk for developing more severe mental health disorders and helps parents learn how to build stronger bonds to their children.*



3. *The Integrated Practice Team (IPT) consists of specialized community service providers that offer knowledge and expertise as they partner with parents to assist in identifying barriers that would prevent children from remaining safely in the home. The Integrated Practice Team (IPT) is available to Duval and Nassau Counties. IPT has impacted our community by planning and integrating services to prevent child removal, shorten removal time and ensuring safeguards are in place for successful reunifications. Because the IPT helps to empower, strengthen and promote healthy families, the family supports and family members attend the IPT staffing's. In SFY16/17, out of the 251 IPT's staffed, from the table 236 were diverted from removal recommendation and/or re-engaged with community services, while 15 required immediate court intervention.*

4. *Community Resource Specialists (CRS) who are co-located with DCF, schools and a community center. They provide community referral assistance to families that are in need and provide additional support to DCF workers. CRS Workers are also an intricate part of the Parent in Need of Assistance process.*

5. *Parent In Need of Assistance referrals come from the Florida Abuse Hotline and 24 hour assistance is provided to parents in need where there is no abuse or neglect present i.e. Emergency housing, service needs, connection to community financial assistance, etc.*