

## PIP Workgroup Worksheet – Service Array

**Relevant Federal Outcomes and Systemic Factors:** WB1, WB2, WB3, and Service Array

**Item or Area Needing Improvement:** WB1 Item #17, WB2 #21, WB3 #22 and #23 // Systemic Factor: Service Array Item #35, #36, and #37

*Access and quality of services for DCFS involved children and families in the areas of education, physical health, and mental health (physical health includes medical issues; mental health includes substance abuse and sexually reactive children).*

Issues	Related Item, Systemic Factor or Data Indicator	Possible Action Steps	Method of Measuring	Responsible Party
<b>2/9/04</b>				
<p><b><i>Problems with access to services:</i></b></p> <ul style="list-style-type: none"> <li>♦ Lack of awareness of resources – physical health (including orthodontic and vision); mental health (including substance treatment, services for sexually problematic behavior, domestic violence); mentoring; housing advocacy; transportation; respite; etc.</li> </ul>	<p>WB1, 2, 3 &amp; Items #17, 22, 23, 36</p>	<ol style="list-style-type: none"> <li>1) Updated Policy Transmittal defining the difference between counseling and therapy services, specifying when to utilize each service, detailing the procedures for accessing each service, and explaining how services will be paid for.</li> <li>2) Review available current resource directories.</li> <li>3) Develop a comprehensive, automated DCFS approved provider resource directory database that is easily accessible to all stakeholders and that lists available resources under specific headings: Physical Health-Medical and Medical Specialists; Physical Health-Dental; Mental Health-Counseling; Mental Health-Therapy; Mental Health-Substance Treatment; Mental Health-Domestic Violence; Mental Health-Sexually Problematic; Mentoring; Transportation; Visitation; Housing Assistance; Respite; etc. and under each heading denote specific Native American and Latino providers. <i>(Use current LAN, HealthWorks, and DHS directories as models)</i></li> <li>4) Update resource directory database yearly when provider contracts are renewed.</li> </ol>		<p>Larry Chasey - Operations</p> <p>Mary Sue Morsch - Placement/Permanency</p> <p>Arthur Bishop - Operations</p> <p>Sam Gillespie - Service Intervention</p> <p>Gail Briggs - Service Intervention</p> <p>Marion Houston - Clinical</p>





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<ul style="list-style-type: none"> <li>♦ Mentoring services</li>   <li>♦ Respite services</li>   <li>♦ Lack of non-crisis after hours and weekend services</li> </ul>		<ol style="list-style-type: none"> <li>1) Evaluate and possibly alter current referral process for Mentoring services to make them more easily accessible and available for longer periods of time.</li> <li>2) Publish list of services currently contracted and how to access them.</li>   <li>1) Clarify and expand respite policy to cover more types of care.</li> <li>2) Publish list of services currently contracted and how to access them.</li>   <li>1) Examine possibility of expanding service hours.</li> <li>2) Advocate for use of flex schedules for DCFS and POS workers, case reviewers, court personnel, etc. Re-visit concept of having regularly established worker call times/days at court.</li>   <li>3) Look into contracts with private providers to determine if there are any clauses requiring after hours services. Add requirement if one does not exist.</li> <li>4) Consider shared-cases between workers who are on flex-time so more coverage hours exists for each case.</li> <li>5) Contact current service providers to determine who has weekend and extended hours (utilize HealthWorks system as a model – they have staff working early morning and later evening hours to reach families and they check with providers to see who has weekend and after hours availability).</li> </ol>		<p>Family Focus group</p> <p>Irene Nelson - for court            Arthur Bishop - Operations - for DCFS            Mary Sue Morsch - Placement/Permanency - for POS            Erwin McEwen - Monitoring/QA - for POS</p> <p>Contracts Division</p>



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<ul style="list-style-type: none"> <li>♦ Lack of follow-up ensuring that mental health issues are fully addressed in a reasonable time frame</li> </ul>		<ol style="list-style-type: none"> <li>5) Emphasize family treatment – focus on assessing needs of all family members and establishing family involvement from the time of entry into the system.</li> <li>6) Better use of Child and Family Team meetings – Need a body other than workers to facilitate these meetings for uniformity, timeliness, and consistency. Establish an initial staffing/service planning meeting to be held immediately after completion of the Integrated Assessment to lay out all recommendations and responsible parties – include providers (e.g., therapists) if specific service recommendations are made. Consider using the initial 30 day Child and Family Team meetings as a forum for this process. Tighten link between Integrated Assessment and service plan. Have Integrated Assessment attached to initial service plan.</li> <li>7) Build expectation of measuring progress into provider contracts. Determine what will be measured and how.</li> <li>8) Training on Integrated Assessment and SACWIS.</li> <li>1) Peer review of well-being services for individual cases to be sure the child/family is receiving exactly what is necessary to meet their needs and that timeframes are appropriate and reasonable.</li> <li>2) Need ongoing staffing to monitor needs/ services. Explore reasons for difficulty getting Child and Family Team meetings arranged in first 30 days of case opening and consider meeting at 90 days as well.</li> </ol>		<p>Integrated Assessment Internal Counseling Workgroup</p> <p>Arthur Bishop - Operations Cretora Barnett - ACR Erwin McEwen - Monitoring/QA</p> <p>Mary Sue Morsch - Placement/Permanency Erwin McEwen – Monitoring/QA Contracts Division Quality Assurance Training Division</p> <p>Quality Assurance</p> <p>Arthur Bishop - Operations</p>



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Issues	Related Item, Systemic Factor or Data Indicator	Possible Action Steps	Method of Measuring	Responsible Party
<ul style="list-style-type: none"> <li>♦ Services toward reunification including housing, respite, child care, substance abuse, domestic violence, employment etc.</li> </ul>		<ol style="list-style-type: none"> <li>6) Consider creating a specialized unit of workers to handle youth cases.</li> <li>7) Develop licensing standards for TLP/ILO programs – focus on basic health and safety issues as the basic social work service components are captured under the standard child welfare licensure.</li> <li>1) Need method for having all reunification services integrated under one provider (or a better system of communication if multiple providers involved) and setting goals to address all issues in realistic time frames.</li> <li>2) Consider specialized workers/therapist for reunification with reduced caseloads and incentives/contracts designed to improve worker retention.</li> <li>3) Consider development of a practice model around reunification.</li> <li>4) Consider use of Parenting Coaches (or homemakers, case aides, or other paraprofessionals) to observe, model, and assist parents with childcare. Provide specific training on what to observe and how to effectively document.</li> <li>5) Create program modeled after New York’s Saint Christopher’s - a comprehensive reunification service model where all reunification issues are handled on-site from the time of case opening.</li> </ol>		<p>Operations</p> <p>Monitoring/QA</p> <p>Mary Sue Morch - Placement/Permanency</p> <p>Arthur Bishop - Operations</p> <p>Cynthia Moreno – Service Intervention</p> <p>Erwin McEwen – Monitoring/QA</p> <p>Mary Sue Morch - Placement/Permanency</p> <p>Arthur Bishop - Operations</p> <p>Cynthia Moreno – Service Intervention</p> <p>Erwin McEwen – Monitoring/QA</p> <p>Reunification PIP committee</p> <p>CWAC Infrastructure Committee</p> <p>Integrated Assessment - to provide recommendations on what specific parenting issues/areas to focus on.</p>

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<ul style="list-style-type: none"> <li>♦ Education services</li> </ul>				
<p><b><i>Instability of mental health services:</i></b></p> <ul style="list-style-type: none"> <li>♦ Agency closures and case transfers– children having to change therapeutic providers if receiving agency has their own in-house clinical services and/or does not have contracts with the same outside clinical service providers through which the children were linked at the former agency.</li> <li>♦ Therapist and caseworker turnover (caseworker turnover may contribute to instability of mental health services if all important case information and information about referrals in progress is not communicated upon a workers departure)</li> </ul>	<p>WB3 &amp; Items #23, 35</p>	<ol style="list-style-type: none"> <li>1) Evaluate what is happening in the transition planning process when agencies close or children change placements.</li> <li>1) Consider having a pool of foster homes that are available to all DCFS and POS. Services stay with that home even if the home is transferred between agencies or agencies do not change when a child’s placement changes. Explore Iowa Model.</li> <li>2) Consider finding way to use prior workers and therapists as consultants on cases even after their involvement has officially ended.</li> <li>3) Clarify and revise current transfer summary policy and create a more standardized, comprehensive summary. Workers to have it written in their contracts that they will provide thorough transfer summaries upon departure. Assure supervisor oversight occurs and workers are given support to accomplish this task (e.g., required to spend their last week in the office completing summaries).</li> </ol>		<p>Family to Family</p> <p>Training Division Contract Division Mary Sue Morsch - Placement/Permanency Erwin McEwen - Monitoring/QA</p>

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Issues	Related Item, Systemic Factor or Data Indicator	Possible Action Steps	Method of Measuring	Responsible Party
<ul style="list-style-type: none"> <li>♦ Time-limited services/service caps</li> </ul>		<ol style="list-style-type: none"> <li>1) Consider allowing DCFS and POS to purchase services from a pool of providers after certain clinical thresholds have been reached (e.g., post-SOC services) - services should follow the placement.</li> </ol>		
<p><i>Support of foster parents in handling mental health and adolescent issues</i></p> <p>***Need foster parent feedback for these recommendations</p>	<p>WB1 &amp; Items#17, 35, 37</p>	<ol style="list-style-type: none"> <li>1) Utilize college level clinicians to provide in-home behavior modification under the supervision of university instructors.</li> <li>2) Develop Adolescent Foster Program - Foster parent recruitment for adolescent homes and training around adolescent issues – consider use of Professional Foster Parents who will be trained to work specifically with youth.</li> <li>3) Need to create foster parent incentives for care of older youth.</li> <li>4) Re-evaluate PRIDE model to add focus on adolescent issues and managing behaviors with older youth or use current providers who specialize in youth issues to provide trainings.</li> <li>5) Consider use of transitional/time limited day programs for children stepped-down from residential to provide another method of temporary support for foster families.</li> <li>6) Develop system where youth and caregivers are automatically qualified for and recommended specific services once the youth reaches adolescence.</li> <li>7) Advocacy for foster parents with providers to help them understand the medical and/or mental health issues of their child and training around these issues.</li> </ol>		<p>Family to Family Training Division</p> <p>City College evaluation of PRIDE model</p>

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Issues	Related Item, Systemic Factor or Data Indicator	Possible Action Steps	Method of Measuring	Responsible Party
<p><i>Provider concerns about consequences of terminating services</i></p> <p>***Is permanency group dealing with this issue?</p>	<p>WB1, 3 &amp; Items #17, 22, 35</p>	<ol style="list-style-type: none"> <li>1) Consider opening SOC to post-adoption for immediate crisis intervention and advocacy for continued services.</li> </ol>		
<p><b>Funding</b></p>	<p>WB 1, 3 &amp; Items # 17, 22, 23, 35</p>	<ol style="list-style-type: none"> <li>1) Study loopholes that allow public and private providers to decline clients or place limits on client referrals.</li> <li>2) Make contracts and funding decisions based on quality of services and needs rather than historical contracting patterns.</li> <li>3) Develop guidelines around payment.</li> <li>4) Develop ways to utilize funds to purchase services in the child/family's community from private providers.</li> </ol>		<p>Contract Division</p>
<p><i>Cultural Issues/Language Barriers</i></p>	<p>WB 1, 3 &amp; Items #17, 22, 23, 37</p>	<ol style="list-style-type: none"> <li>1) Training on cultural issues.</li> <li>2) Consider offering scholarships and guaranteed jobs for bi-lingual Master's level students willing to become caseworkers.</li> <li>3) Offer financial reimbursement for workers to learn Spanish. Send seasoned clinicians to Spanish for Professionals classes.</li> </ol>		<p>Training Division</p>