Family Preservation Call agenda and Questions:

I. Invoicing (Dan Gelb on the call as well)—Ability to invoice launched today.
   a. Communication sent yesterday – please let us know if you did not receive it
   b. Overview
      i. System will be down tonight to deploy Family Preservation invoicing function; best to wait until Monday morning
      ii. Same mechanisms apply – manual or file import (cxv or xml)
      iii. Date range feature will be available – bill via per diem
         1. First date of service will be first contact (virtual allowed for now)
         2. End date of service would be end of the month (one line)
         3. Next month would be first to end of the month (one line)
         4. Stop billing on the date the referral or case CLOSES – not the last date of face to face contact
         5. If removal is not formal and indefinite, you can continue invoicing
            a. Example is if caregiver goes to Detox for a limited time – you can continue to invoice
         6. Rate will auto-fill based on number of children in the family/referral
            a. Children who are not part of the case/IA will not be included
            b. Children who are born during the life of a case – new referral will be necessary
         7. Referral should include all eligible children formally involved in the case
            a. KidTraks will recognize this and calculate per diem
            b. KT will not let you submit for a higher amount; if you change pre-filled rate to lower rate, KT will notify you but you may move forward
         8. Select other items will auto-fill
         9. New invoice service type **FAMPRES PER DIEM** – important to select this service type!
            a. Will be at the top of the drop down list
            b. DO NOT select 'Family Preservation' service type
         10. Monthly report will be necessary – invoicing will not be reviewing individual services provided throughout the month
         11. Follow naming guidelines previously provided when naming monthly report
            a. Naming other documents can be logical regarding the content of the document – these would not be associated with invoicing so naming conventions are less important
         12. Email DCSPaymentResearchUnit@dcs.in.gov

II. Initial Assessments— as we discussed during our last call, this continues to be a bit of an issue, and we have some cases where the required assessment was not uploaded and the contracts as is necessary. Let's discuss…

a. Many Initial Assessments are very generic – no goals, no clinical insight, does not provide information to court; good tools are used and scored, but the assessment only provides score with no narrative
    i. Court MUST have a good understanding of what the initial assessment includes
    ii. How will you plan to start working with the family; what EBP will you use?
    iii. Initial assessment might take more than one visit
    iv. EBP and goals can change over time – this is expected
b. Safety plan and initial assessment within 7 days of first contact
c. FCMs and courts are looking for good assessments – providers who do this will stand out among referral sources as Family Preservation services increase

III. Discussion around separate referrals— when is this appropriate?

a. Primarily – one referral to one provider should be in place and completing all services
    i. Measuring outcomes
    ii. Provider accountability
    iii. Convenience and organization for families
    iv. One report for judge to read
b. Some exceptions may be needed
    i. Detox, Psych Evaluation, substance use – as examples
    ii. NOT every referral for Family Preservation will justify a separate referral for exceptions in services
        1. Exceptions come in when the team realizes there is an additional need AFTER Family Pres has been in place and new need is identified
        2. Even then, Medicaid or other insurance should cover first if applicable
            a. Families should not need DCS involvement to get substance use services
            b. Families should be able to continue medically necessary treatment after DCS case closure
c. If it is a new case, the team should thoughtfully consider what needs are and which provider can best facilitate those needs under one referral

IV. Face-to-face expectations and Phase 5 of "Back on Track"

a. Currently, initial contact with family can be virtual
b. Phase 5 now scheduled to launch July 18
c. Once we enter Phase 5 – contact that turns on per diem will be required to be face to face
    i. You will contact family by phone in advance to ask screening questions and ensure it is safe for you
        1. If the family/household has COVID-19, we <u>do not</u> expect you to go into the home

2. If you learn during the call someone has COVID-19, talk to the team to determine how best to serve the family

ii. Precautions should be in place among your staff – masks, hand washing, etc.

iii. Additional services (following the model) can be a combination of face to face and virtual contacts

iv. Weekly face to face contact will still be required

1) Can an agency accept a family preservation referral for a client with domestic violence history if we only provide services to the survivor and child (and not provide the batterers intervention services)? Would the batterer's services then be considered a specialized/outside referral? Or do we need to reject the referral and have the FCM send the case to an agency that provides both services?
A: This will most likely depend on the circumstances of the specific case, and we would rely on providers with specific expertise to help advise us on such cases. What is the nature of the ongoing relationship between the perpetrator, victim and child? Is the perpetrator an active participant with the family, or is there a no-contact order in place with no intention of having the perpetrator involved with the family targeted for preservation? Often, it is not advised for the perpetrator and the victim to have the same therapist, and, so, are there multiple therapists with proper training available at one specific agency who has a FPS contract? These are the kinds of questions that would need to be considered as to whether an agency would be appropriate for family preservation with a case involving domestic violence. As with any other presenting issue, however, if you don't have the expertise to effectively treat a presenting condition, providers should disclose this so that DCS can consider making a referral to a different provider, or, perhaps, in addition to your agency.

2) Can an agency that is not a substance abuse facility accept a family preservation referral for a client if their substance use can be treated through the use of their Medicaid? As an example: if the client needs IOP and their Medicaid will cover this, would we provide the other services for the family and use support work to use the Medicaid for IOP? Or do we reject the family preservation referral and have the FCM send it to a substance abuse treatment facility? We are getting different answers from different supervisors on this issue specifically.
A) This would again be determined on a case-by-case basis based on a specific case's circumstances, but, as is the case with Family Preservation Services in general, we really want to have one and only one provider agency in place for families for the vast majority of these cases (and we especially only want one and only one DCS referral in place for these cases as often as possible). Is there already an SUD provider in place working with the individual prior to our opening the IA? If so, does that provider have a FPS contract? If the answer is yes to both, we should refer FPS to that provider. If, the answer is yes to the provider being in place, but "no" to them having an FPS contract, provided they are deemed as doing good work with the individual, we can leave them in place and bring in a separate FPS provider, even one who doesn't treat SUD. I know many people point to "Outpatient SUD Treatment" being listed in the service standard as a service that may be referred in addition to FPS, but, that is listed there for the scenarios where we didn't know going in that SUD was present (or likely present), so, we

brought in a different provider to address other presenting issues (parent education, for example) and then after that provider has been in place (and hopefully doing very good work) for an extended period we then learn that SUD is potentially present. In that scenario, we wouldn't want to replace the FPS provider, and, instead, would look to refer for SUD treatment, hopefully funded by Medicaid or another 3rd-party payor so that the family can still have access to that support when our case closes.

3) Should IA and in-home CHINS cases that were opened before June 1st be moved to a Family Preservation referral? We have had a couple local DCS offices ask us about this.
A: Yes, this is allowable and even encouraged if that is what makes sense for the family. The main focus is that we do not want to disrupt services that are in place and are proving to be effective for specific families. So, when we are looking at existing cases that opened prior to June 1, the Child and Family Team involved must consider what would be lost if a referral is made to family preservation services (because, again, with FPS, we want one and only one referral in place for the vast majority of families). If what has been in place doesn't seem to be helping, or, if there's only one provider in place and that provider has an FPS contract, a referral to FPS would be very appropriate. If, on the other hand, there are currently 3 providers in place and the family is responding well, a referral to FPS is not advised.

4) How do we know if the case is a CHINS or IA?
    a. If you have a referral for Family Preservation, the CHINS/IA difference is not important.

5) We are getting traditional referrals on cases that are new, in home CHINS or IA with no removals. Should that be happening?
    a. No – if you find this is happening, reach out to the FCM to get more information. If it is in fact a new case with no removal, you should ask them for a Family Preservation. Point them to the DCS Family Preservation page on the DCS website if they have more questions.

6) If a family is 'dodging' you and you are not able to see them, what do you do?
    a. If a family is actively avoiding DCS/services, this is a concern
    b. Contact the FCM/Supervisor/LOD/then DCS Hotline
        i. This would be a safety concern, if you cannot assess for safety
    c. If it is an IA – IA's are voluntary; if a family is not cooperative then the team may need to make a decision regarding the status of the case.
    d. If the FCM asks you to go three times, you make the effort and no one answers, you would in theory not get paid.
        i. Talk to the FCM and the Services Team. We can likely work it out to get the per diem turned on in these situations

7) Does the safety plan need to be a separate document or can it be part of the initial assessment?
    a. These are separate documents, to be uploaded separately
    b. Both due within the first 7 days of the referral

c. DCS has not dictated specific forms, you may develop your own.

8) Safety Visits – can we see family members at different times throughout the week?
   a. YES. You need to see all household members each week, but it does not have to be at the same time
   b. If you miss a child, for example, you need to see them at a different time throughout the week.
   c. If you have safety concerns regarding a child, please reach out to the FCM and call the DCS hotline as appropriate.