CT BHP VALUEOPTIONS
FOSTER CARE PILOT PROJECT
QUALITY IMPROVEMENT ACTIVITY (QIA)

Date: March 12, 2010

The **Foster Care Pilot Project** is a quality improvement activity designed to address the higher disruption rate of children in a first time foster care placement who have a history of behavioral health treatment prior to placement. The goal of this activity is to prevent disruption by intervening with foster parents to ensure continuity of behavioral healthcare treatment in the new placement and to immediately assess for the need for additional treatment for the child or support services for the foster parent(s).

Background of the Quality Improvement Activity

During 2007, ValueOptions, in collaboration with the Connecticut Department of Children and Families (CT DCF) and Department of Social Service (DSS), conducted a retrospective analysis of data on children and adolescents placed in DCF oster care to identify any relationship between use of behavioral health services and disruption from a first or second foster home placement. This project grew out of clinical discussions with the Departments regarding children who experienced delayed discharges from emergency departments (ED). An unknown number of children were brought to the ED by foster families who felt they were no longer able to care for these children as a result of their behavioral health problems. This led to questions regarding whether a foster child appearing in the ED should trigger an urgent behavioral health intervention to prevent a possible disruption from the foster care placement. Early in 2007, a decision was made to include a Performance Target in the Year Two contract between ValueOptions and the Departments that would determine if there is a correlation, hereafter described as a relationship, between disruption of a first or second foster home placement and prior use of behavioral health services.

In June 2007, DCF provided CT BHP with a file extract containing data regarding the children who had been removed from their homes and placed in foster care between July 1, 2006 and December 31, 2006. This allowed CT BHP to attach any authorization data that might have been entered into the information system during the six (6) months before removal and the six (6) months after removal, as well as ED data routinely received from the Department of Social Services (DSS), in order to then analyze the data for possible relationships between use of services and disruption.

An analysis of the findings of the study was submitted to the Departments in November 2007. The analysis revealed that children aged 4 to 18 who had received behavioral healthcare services in the 18 months prior to first time placement in foster care were significantly more likely to disrupt from placement than children who had not received behavioral healthcare services. Youth in foster care who were authorized for inpatient or intermediate level of care before placement were more likely to subsequently disrupt from placement than those authorized for outpatient services.

The recommendation that resulted from these findings was to develop an intervention with youth in a first foster care placement who had been authorized for behavioral health treatment during the 18 month period prior to their placement. During the latter half of 2008, CT BHP worked with several DCF Area Offices across the state to develop a protocol for the intervention. Initially, two DCF Area Offices agreed to pilot the program (Waterbury and Norwich). The pilot began in January 2009. Three more DCF Area Offices agreed to participate since that time (Hartford, New Britain, and Manchester).

Qualifications for Inclusion in the Quality Improvement Activity

In order to qualify for the study, the member must :

- Be between the ages of 4 to 18, who are
- Placed in foster care for the first time (as opposed to a safe home), or who are placed in foster care after having been reunited with their birth parents for more than 3 years,
- Have been authorized for behavioral health treatment within the past 18 months, and
- Be a CT BHP member covered by HUSKY A or B (Medicaid)

Protocol for the Quality Improvement Activity:

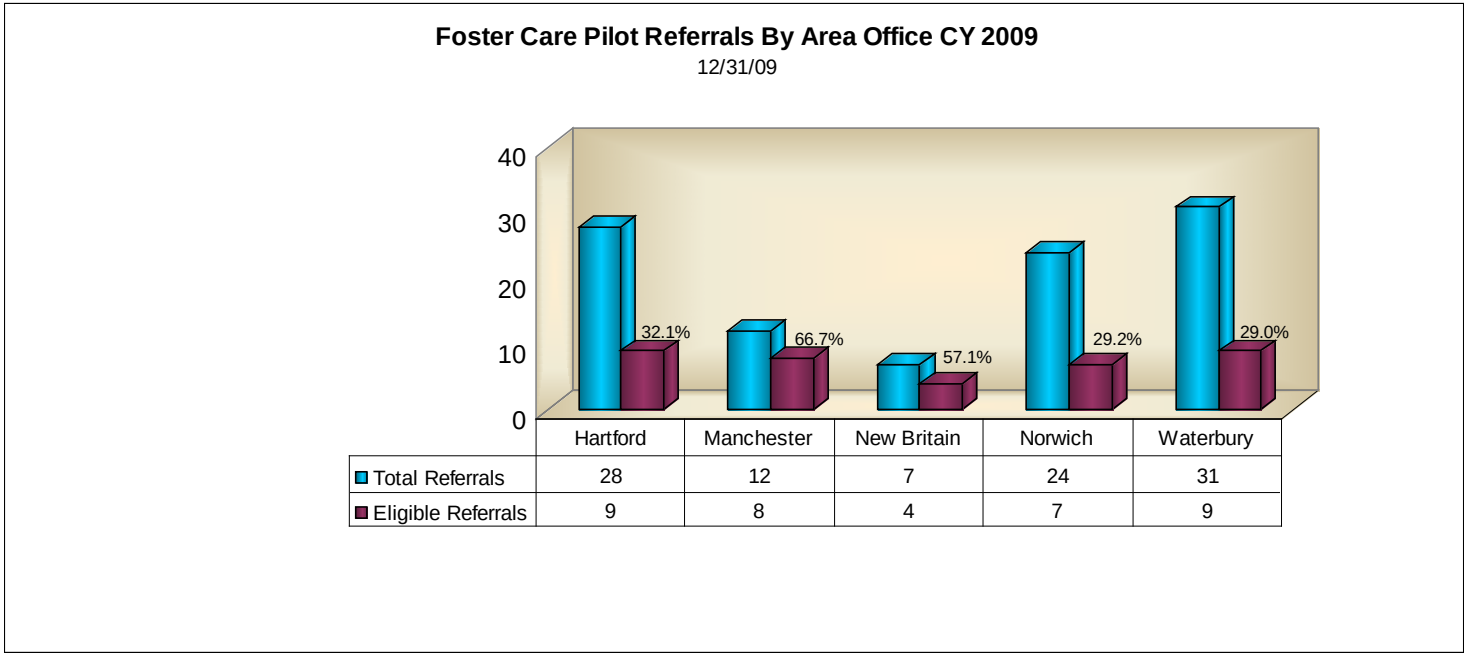
- Each participating DCF Area Office Foster Care "Matcher" notifies the Central Office DCF liaison of any foster care placements within 24 hours of the removal from the home.
- The DCF Liaison identifies active HUSKY members and notifies the CT BHP/QM department liaison.
- QM liaison determines whether the identified member meets the activity's criteria and, as appropriate, assigns member to an Intensive Case Manager (ICM) and Peer Specialist (PS). The ICM and PS are assigned based on DCF Area Office location.
- A case is considered "urgent" if the child has been authorized for an intensive level of care within the past 6 months
    - Telephonic outreach to the DCF worker by the ICM and to the foster family by the PS is initiated within1 business day for cases considered "urgent" and 3 business days for all other cases
    - For urgent referrals, member information is sent over to the ICM and PS in the same business day and outreach was expected to take place within that day.
- Non-urgent referrals were made for members with authorizations for lower levels of behavioral health care within the past 18 months.
    - The turn-around time for these referrals is attempted contact within three business days. In all cases attempts at contact were made far earlier than 3 business days.
- Upon receipt of the case, the **ICM**
    - Researches the child's behavioral health history in AIS and assesses current clinical needs via communication with the DCF Worker and PS after they have spoken with the foster parents.
    - Reaches out to the DCF worker assigned to the member and provides assistance with coordinating appropriate care to assist with the transition into foster care.
    - Outreaches to the members current behavioral health provider in order to provide additional support.
    - Summarizes the history and forwards the information to QM and DCF
    - Completes the Treatment and Crisis Plans
- Upon receipt of the case, the **Peer Specialist**
    - Contacts the foster family to assist in identifying immediate needs and to offer support in the form of phone contact, referrals for traditional and non-traditional services, (community supports, mentors, after school programs, etc) and anything the foster parent might need assistance with during the fragile transition period
    - Works in coordination with the ICMs and DCF to identify the needs of the family and child
    - Works with the foster family to assist them in gaining access to behavioral health services as well as necessary supports and resources in their community.
    - Encourages each family to obtain services
    - Works to address the identified needs as quickly as possible.

Referrals for the QIA

The table below displays the total referrals from each of the participating area offices and the percentage of those eligible for the activity.

Area Office/ Pilot Start Date	Total	Total Percent	Total Eligible	Total Eligible Percent
Hartford (7/09)	28	27.5%	9	32.1%
Manchester (9/09)	12	11.8%	8	66.7%
New Britain (8/09)	7	6.9%	4	57.1%
Norwich (1/09)	24	23.5%	7	29.2%
Waterbury (1/09)	31	30.4%	9	29.0%
Total	**102**	**100.0%**	**37**	**36.3%**

- Norwich and Waterbury began participating in the study in January 2009. Hartford (July 2009), New Britain (August 2009) and Manchester (September 2009) joined the study later in the year.
- The highest volume of referrals, 31 (30.4%) came from the Waterbury Area Office; out of those 9 (29%) were eligible.
- Hartford had the next highest volume of referrals (28, (27.5%) despite the fact that they participated in the QIA for the shortest period of time. Of those referrals, 9 (32.1%) were eligible for activity.
- New Britain submitted the least number of referrals (7; 6.9%) and of those, 4 (57.1%) were eligible for the activity.



Demographic Information-

The table below displays demographic information regarding the age and gender of the referrals from the participating area offices.

Age Category	Total Male Referrals	Total Female Referrals	Total Referrals
Age 4-7	17 (43.6%)	22 (56.4%)	**39**
Age 8-11	7 (38.9%)	11 (61.1%)	**18**
Age 12-15	10 (47.6%)	11 (52.4%)	**21**
Age 16-18	4 (16.7%)	20 (83.3%)	**24**
Total	**38 (37.3%)**	**64 (62.7%)**	**102**

The demographic information above indicates that a higher percentage of HUSKY eligible females (67.6%) were placed into foster care than males (32.4%) across all participating DCF area offices. More females were placed than males in every age category. The largest discrepancy between male and female placement occurred in the 16 to 18 year old age category when 20 of the 24 referrals/placements (83.3%) were females.

The table below displays a comparison of the age demographics of members referred by the participating area offices to those of members eligible for the QIA.

Age Category	Total Referrals	# Eligible	% Eligible
Age 4-7	39	10	25.6%
Age 8-11	18	7	38.9%
Age 12-15	21	7	33.3%
Age 16-18	24	13	54.2%
Total	**102**	**37**	**36.3%**

The highest number of referrals to the activity from the Area Offices were of children in the 4 to 7 age bracket. This age bracket also had the lowest percentage of children eligible for the activity. Children aged 16 to 18 had the highest percentage of eligible referrals.

The table below displays demographic information regarding the effect of gender and age category on eligibility for the activity.

Age Category	Eligible Males	Eligible Females	Total Eligible
Age 4-7	5 (50%)	5 (50%)	10
Age 8-11	3 (42.9%)	4 (57.1%)	7
Age 12-15	4 (57.1%)	3 (42.9%)	7
Age 16-18	0	13 (100%)	13
Total	**12 (32.4%)**	**25 (67.6%)**	**37**

More than twice as many females as males were eligible for the activity. This aligns with the earlier finding that twice as many females were placed in foster care. However, this difference is almost solely accounted for by the differences in gender eligibility in the 16 to 18 year old age category when of the 13 eligible members, no males were included. Below the age of 16, there were essentially no gender differences in eligibility for the activity.

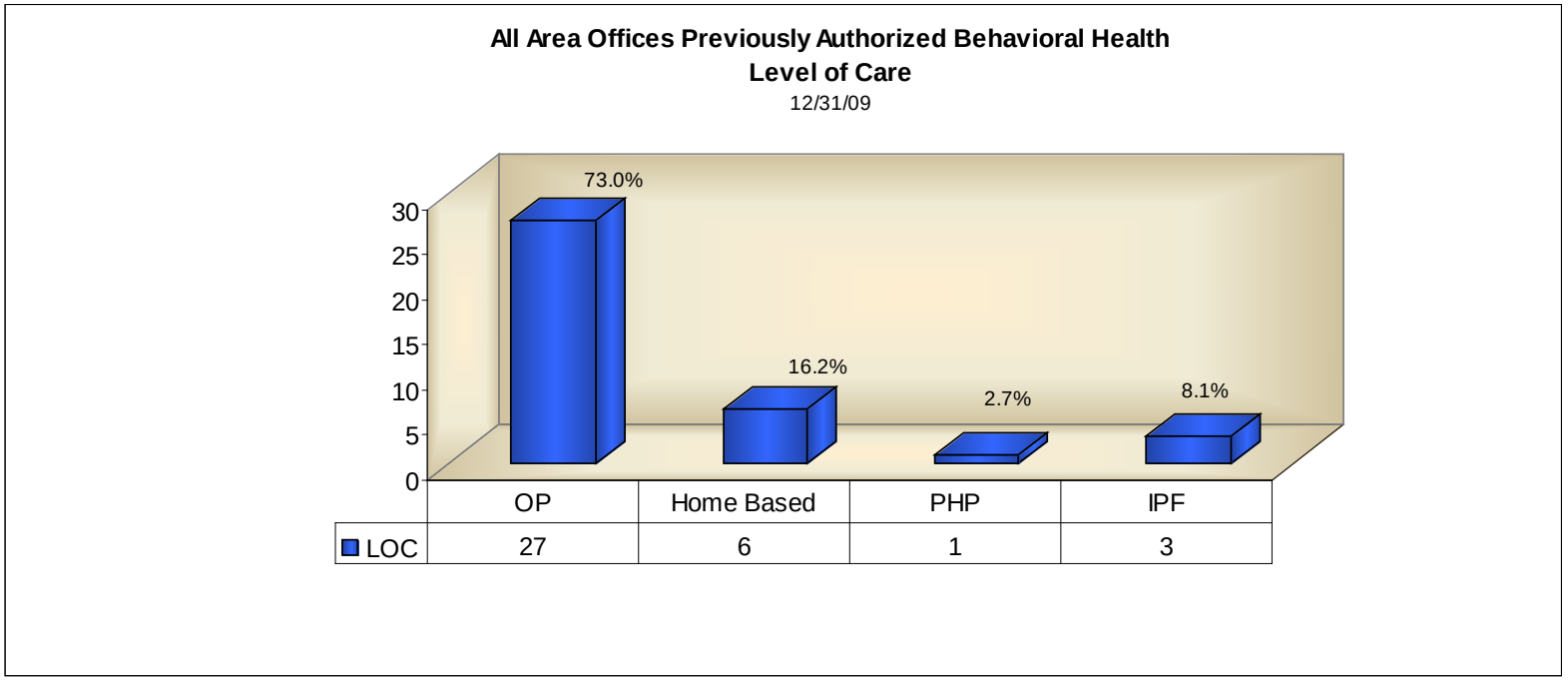
The table below displays demographic information broken out by DCF Area Office. It shows the total numbers of eligible members referred and their percentages by gender.

Area Office	Total Eligible	% of Total Eligible	Eligible Males	% of Total Eligible Males	Eligible Females	% of Total Eligible Females
Hartford	9	24.3%	4	44.4%	5	55.6%
Manchester	8	21.6%	2	25.0%	6	75.0%
New Britain	4	10.8%	2	50.0%	2	50.0%
Norwich	7	18.9%	2	28.6%	5	71.4%
Waterbury	9	24.3%	2	22.2%	7	77.8%
Total	**37**	**100.0%**	**12**	**32.4%**	**25**	**67.6%**

The largest percentage of members eligible for the activity came from the Hartford and Waterbury area offices. As noted above, while overall more females than males are placed in foster care and more females than males were eligible for the activity, exceptions to this finding came from the Hartford and New Britain area offices where equal or nearly equal numbers of females and males were eligible for the study.

Previously Authorized Level of Behavioral Healthcare.

In order to qualify for the foster care project, members needed to have had behavioral healthcare services within the 18 months prior to being removed from their home. The graph below shows the types of behavioral healthcare services that were authorized prior to removal. In those instances when the member was authorized for more than one level of care, the member is included in the highest level of care authorized.



Members eligible for the activity had most frequently used (73%) outpatient services prior to being removed. Home based services (IICAPS, MDFT, and FFT) were the second most frequently authorized at 16.2%, followed by inpatient (8.1%) and partial hospitalization (2.7%).
There were three members with IPF authorizations prior to removal and they were treated as urgent cases due to the intensive level of care and potentially high level of support that would be needed to maintain the youth in placement.

Acceptance of Services

The following charts provide information regarding the number of families who received new authorizations and/or Peer Support (PS) services within 45 days of placement. The PS services include support by CT BHP staff members who are not clinicians but who have lived experience of the behavioral health system either through their own service use of use by their children. The PS services are in the form of phone contact, referrals for traditional and non-traditional services (community supports, mentors, after school programs, etc) and help with anything else the foster parent might need assistance with during the transition period.

The following charts are broken out by Area Office, Gender, and Age. Some families are duplicated if they received both a new authorization for treatment and also accepted PS services. Please view these analyses with caution; the sample sizes are small.

Acceptance of Services by Area Office

Area Office	Total Eligible Number	# Members with New Auth	Percent of Members with New Auth	# Members with PS Accepted	Percent of Members with Acceptance of PS Services
Hartford (7/09)	9	0	0.0%	6	66.7%
Manchester (9/09)	8	3	37.5%	1	12.5%
New Britain (8/09)	4	2	50.0%	2	50.0%
Norwich (1/09)	7	6	85.7%	3	42.9%
Waterbury (1/09)	9	5	55.6%	5	55.6%
Total	**37**	**16**	**43.2%**	**17**	**45.9%**

- Of the 37 members eligible for the study, less than half accepted a new authorization for additional behavioral healthcare services or peer support services. Please keep in mind that these children were already receiving services prior to placement and that these new authorizations only reflect the addition of new services.
    - 16 (43.2%) of them received at least one new authorization for behavioral healthcare within 45 days of placement.
    - 17 (45.9%) accepted PS services.

With regard to specific Area Office findings:

- There are no consistent trends across the area offices.
- 85.7% (6) of Norwich families accepted a new authorization for behavioral healthcare services within 45 days of placement while 42.9% (3) accepted PS services.
- Hartford families had no new authorizations within 45 days of placement but 66.7% accepted PS services.
- Waterbury and Norwich had the same percentage of families (55.6% and 50% respectively) with new authorizations and PS services.
- Manchester had the fewest families who accepted authorizations (37.5%) or PS services (12.5%).

Acceptance of Services by Age Category

Total Eligible Age	Total Eligible Number	New Auth	Percent of New Auth	Peer Support Accepted	Percent of PS Accepted
Age 4-7	10	4	40.0%	4	40.0%
Age 8-11	7	4	57.1%	3	42.9%
Age 12-15	7	3	42.9%	3	42.9%
Age 16-18	13	5	38.5%	7	53.8%
Total	**37**	**16**	**43.2%**	**17**	**45.9%**

- There are no clear trends in acceptance of services by age category. Again, sample sizes are small and any trends must be viewed with caution.
- The highest percent of families who accepted new authorizations was 57.1% for children in the 8 to 11 year old category.
- With regard to acceptance of PS services, the highest rate of acceptance of services (53.8%) was for families fostering 16-18 year olds.

Acceptance of Services by Gender and Age Category

Male Age	Total Eligible Number	New Auth	Percent of New Auth	PS Accepted	Percent of PS Accepted
Age 4-7	5	1	20.0%	2	40.0%
Age 8-11	3	2	66.7%	1	33.3%
Age 12-15	4	2	50.0%	2	50.0%
Age 16-18	0	0	0.0%	0	0.0%
Total	**12**	**5**	**41.7%**	**5**	**41.7%**

Female Age	Total Eligible Number	New Auth	Percent of New Auth	PS Accepted	Percent of PS Accepted
Age 4-7	5	3	60.00%	2	40.0%
Age 8-11	4	2	50.00%	2	50.0%
Age 12-15	3	1	33.30%	1	33.3%
Age 16-18	13	5	38.50%	7	53.8%
Total	**25**	**11**	**44.00%**	**12**	**48.0%**

- Overall, there were no major differences by gender of the foster child with regard to foster families accepting services.
- The “Ns” within the age categories broken out by gender are small; trends can not be safely identified.

Disruptions and Reunifications

For the purposes of the following analysis, disruption is defined as any movement of the youth following the initial foster care placement unless the move was for reunification.

Disruption and Reunification Across Participating Area Offices and by Area Office

The table below displays the number and percentage of disruptions and reunifications by Area Office.

Area Office	Total Eligible	Disruptions	Percent	Reunifications	Percent of Reunifications
Hartford	9	3	33.3%	0	0.0%
Manchester	8	4	50.0%	1	12.5%
New Britain	4	1	25.0%	0	0.0%
Norwich	7	2	25.0%	2	28.6%
Waterbury	9	0	0.0%	3	33.3%
Total	**37**	**10**	**27.0%**	**6**	**16.2%**

- Of the 37 youth who met the criteria for involvement in the improvement activity, 10 (27%) disrupted from their placement within 45 days. This is lower than the disruption rate found for children with a history of previous behavioral health care during the analysis of disruption rates conducted in 2008 (52%).
- The Hartford Area Office had the highest rate of disruption (4 of 8 youth or 50%) and Waterbury had the lowest rate of disruption 0 of 9 youth or 0%)
- Waterbury also had the highest rate of reunification (3 of 9 youth or 33.3%).
- New Britain had the lowest rate of reunification (0 of 4 youth or 0%); however, they also had a low number of youth eligible for the activity so that this variation should be viewed with caution.

Disruptions and Reunifications by Gender

Gender	Total Eligible	Disruptions	Percent Disruptions	Reunifications	Percent Reunification
Male	**12**	**1**	**8.3%**	**3**	**25.0%**
Female	**25**	**9**	**36.0%**	**3**	**12.0%**

- Males were less likely to disrupt than were females.
- Males were also more likely to be reunified with their biologic family than were females.

Disruptions and Reunifications by Age Groupings

Age Groupings	Total Eligible	Disruptions	Percent Disruptions	Reunifications	Percent Reunifications
Age 4-7	10	0	0%	1	10%
Age 8-11	7	2	28.6%	3	42.9%
Age 12-15	7	2	28.6%	0	0%
Age 16-18	13	6	46.2%	2	33.3%
Total	**37**			**6**	

- Youth in the Age 16-18 category were most likely to disrupt from their placement (46.2%).
- Youth in the Age 8-11 category were most likely to be reunified with their biologic family (42.9%).

Disruptions and Reunifications by Age Groupings and Gender

Male	Total Eligible	Disruptions	Percent Disruptions excluding reunifications	Reunifications	Percent of Reunifications
Age 4-7	5	0	0.0%	1	20.0%
Age 8-11	3	0	0.0%	2	66.7%
Age 12-15	4	1	25.0%	0	0.0%
Age 16-18	0	0	0.0%	0	0.0%
Total	**12**	**1**	**8.3%**	**3**	**25.0%**

Female	Total Eligible	(Excluding Reunifications) Disruptions	Percent Disruptions excluding reunifications	Reunifications	Percent of Reunifications
Age 4-7	5	0	0.0%	0	0.0%
Age 8-11	4	2	50.0%	1	25.0%
Age 12-15	3	1	33.3%	0	0.0%
Age 16-18	13	6	46.2%	2	15.4%
Total	**25**	**9**	**36.0%**	**3**	**12.0%**

- While youth in the Age 16-18 age category were most likely to disrupt, this category is made up completely of females. There were no males in the Age 16 to

18 age category.
- The remainder of the cells are too small to comment on trends.

Relationship between Services Received and Disruption

There does not appear to be any clear relationship between the receipt of additional behavioral health services or PS services and disruption**.**

- Of the 27 youth who either did not disrupt from their placement or who were reunified with their biologic family
  - 8 had only additional behavioral health services authorized
  - 15 had either additional behavioral health services or PS services, and
  - 4 had no additional behavioral health services or PS services.
- Of the 10 who disrupted,
  - 6 had only additional behavioral health services authorized
  - 3 had either additional behavioral health services or PS services, and
  - 1 received no additional behavioral health services

Summary

Although it can not be said with certainty that the intervention prevented disruption, the activity of offering and providing early behavioral health and support services to youth with a first placement in foster care and a recent history of having received behavioral health services may have had a positive impact on disruption rates. While the number of participants in the activity was small (37), the disruption rate of 27% within 45 days was lower than the disruption rate found during the retrospective data analysis of youth with a first placement and a history of previous behavioral health treatment conducted in 2007 (52%). It may be that foster families simply knowing that there were services and/or support available should they need it had a positive effect on their willingness to stick with troubled youth.

Interestingly, less than half of the foster parents were willing to accept an authorization for behavioral health services or for peer support services. Of the 37 members eligible for the study, 16 (43.2%) of them received at least one new authorization for behavioral healthcare within 45 days of placement and 17 (45.9%) accepted PS services. This finding is at least partially explained by the difficulty in reaching foster parents by telephone. In some cases, there was never any direct contact between CT BHP staff and the foster parent. Telephone messages were left for foster parents and follow-up letters were mailed whenever foster parents could not be reached directly.

At the same time, this finding is in line with the feedback received during focus groups with foster parents conducted during 2007. Those foster parents reported that they did not feel that behavioral health services were always necessary or helpful. Instead, they requested more community support services as well as quicker access to behavioral health services when they were necessary. The intervention of contacting foster parents within days of placement and of offering both behavioral health services and/or peer support was designed to address those stated needs.

The low number of eligible participants was the most significant barrier to this project. A total of 102 referrals for this quality improvement activity were received. Of those, only 37 were found to be eligible for the activity.
Other barriers included:

- The difficulty in reaching the foster parents by telephone.
- The difficulty of ICMs reaching DCF workers by telephone
- DCF staff having concerns about sharing information with CT BHP staff as a result of their lack of knowledge about the activity and/or concerns about sharing PHI.

The last two barriers were addressed several months into the activity by sending an e-mail to the DCF worker involved with each case that included a brief description of the activity, the name of the ICM that would be contacting them, and a DCF point person from their Area Office who could answer their questions about the activity.

Recommendations:

1. Discontinue the project as a quality improvement activity given the small number of eligible participants.
2. Consider the continuation of service to this high risk population by including them in the CT BHP ICM program as “youth at risk” youth.
3. Consider expanding the population receiving the intervention to include:
    a. Children placed initially in Star homes and then moved to foster care
    b. Children with multiple disruptions from placement