FREQUENTLY ASKED QUESTIONS

1. Why aren't JD/JS cases included?
   A: These are *family* services that utilize Evidence-Based Practices (EBPs) to achieve our goal of safely preserving more families. JD/JS cases involve one youth who's ordered to comply with services, and, when you look at the EBPs that have research support, they *all* involve caregivers. For these services to be effective, the caregivers must be involved, and, there isn't that assurance with JD/JS cases. Dual status cases, however, provided there has not been a formal and indefinite removal, do qualify for Family Preservation Services.
   Lastly, these services were developed largely as a product of the CWG assessment which highlighted the extremely high number of out-of-home CHINS cases relative to our neighboring states and the national average, as well as a product of HEA 1001 that called for a "per-diem reimbursement model for 'family preservation services'", which we interpreted as traditional CHINS/IAs families.
   DCS is certainly willing to continue discussing how this could look for JD/JS cases, however, and would be interested in hearing from stakeholders as to how to best identify these cases types for services that are this intensive.

2. Why aren't these services child-specific?
   A:There's just not good evidence that one-on-one services with youth is at all effective or predicts good outcomes for them, but, there is LOTS of research that supports keeping kids out of foster care does. Therefore, the focus of these services is on working with caregivers so that they can learn how to safely parent their children. In addition, we wouldn't be entering into an IA or petitioning for an in-home CHINS case due to a specific service need with a youth—we have CMHI and many other services outside of formal DCS involvement if the service need is something related to the child alone. That said, the providers under contract for Family Preservation Services do have the ability to deliver *comprehensive* services and likely can address something specific with a child (like treating a child's ADHD, mood disorder, developmental disorder, etc.), either through the per diem or even by billing Medicaid for these services that would be tied to a formal diagnosis and thus medically necessary.

3. Why aren't TTV cases included?
   A: The statute says "family preservation services", not reunification services, but, more importantly, if a family managed to progress in their case to the point where they are on TTV, the services that have been place for that family have likely been effective and we wouldn't want to disrupt them for families. Where it makes sense, however (like a child who was only removed for a very short time and whose service provider also has a Family Preservation Services contract), we can refer for FPS.

FREQUENTLY ASKED QUESTIONS

4. Aren't providers just going to cut corners and deliver models that make them the most money?
   A: They may, but, for the first time we are going to be able to meaningfully track outcomes to the provider level since we'll only have one provider in place for the vast majority of these cases, and, providers know that we are indeed tracking outcomes. These are only 13-month contracts, so, providers are highly incentivized to get families to good outcomes, and, thus dis-incentivized to "cut corners". With FPS, outcomes matter much more than hours, and, since providers wereactively involved in the creation of these services and see the many benefits of a per-diem approach, they want to focus on helping families and maintaining their contracts. They must be considerably more accountable with this approach than with fee-for-service with multiple providers working with each family.

5. You say this will improve continuity of care for families. How?
   A: Right now the majority of our contracted providers don't accept any payments from 3rd parties such as Medicaid or other health insurance, and, as a result, when DCS cases close, families commonly lose all of their supports as there isn't a funding source for the provider to stay involved. With FPS, providers are free to bill 3rd-party payers for things that health insurance should pay for, like treating medically-necessary conditions like depression, substance use disorder, bipolar disorder, etc., and still receive the per diem (provided they aren't billing both Medicaid and DCS for the same intervention). This way, when DCS closes our case, that parent can still receive treatment for those diagnosed conditions from the same people who helped their family get through their DCS case, thus increasing the chances that the parent continues to receive services even after we close. This will lead to better continuity of care for families, and, hopefully a reduction in repeated maltreatment for children.

6. Does family pres include substance use disorder treatment? What about drug screens?
   A: Yes, we have dozens of providers under contract who have the ability to treat substance use disorder all across the state, including almost all Community Mental Health Centers (and many non-CMHCs who can treat SUD as well). Therefore, when FCMs, Child and Family Teams, or Courts suspect SUD, they are highly encouraged to send the FPS referral to a provider who has the ability to treat that condition to minimize the number of provider agencies working with each family (which is a clear goal of FPS). FPS does NOT include drug screens, however, and those will continued to be referred separately (though, certainly if a provider uses drug screens in some fashion as a component of their treatment for SUD, they are free to do so). Many treatment providers do not feel that the frequency of DCS drug screens is clinically appropriate, and, thus, they should focus on treatment and not on screens.

FREQUENTLY ASKED QUESTIONS

7. Are these services available statewide, and, is there enough access for both IAs and In-Home CHINS cases?
   A: Yes. Statewide for all IAs and all in-home CHINS cases, with one per diem rate for both case types and in every county (the per-diem rate is $113.47/day for families with up to 2 children, and an additional $24.25 for each additional child). We collaborated closely with our provider community in the development of these services, and had a tremendous response to the RFP that was used to procure these contracts, resulting in 96 total provides being awarded contracts for these services. Every region has several providers under contract—the region with the fewest contracted providers is Region 6, who has 7 contracted providers, and, the region with the most is Region 10, who has 42 providers under contract. If anyone would like to know the specific providers under contract in any DCS region, they are encouraged to reach out to ChildWelfarePlan@dcs.in.gov .

8. Are there enough providers in __________ County/Region? We can't find providers to serve there as it is.
   A: Yes, every Region has at least 7 providers.

9. I need a psych eval/detox/human trafficking/batterer's intervention service. How can I get that now that Family Preservation Services have launched?
   A: Those are services that are likely to fall outside of Family Preservation Services (though, not necessarily—we do have agencies with on-staff psychologists, detoxification programs, human trafficking and batterer's intervention expertise under contract for FPS), and, if needed, we can and will still refer for these services separately. No services went away with the launch of FPS, but our hope is that the vast majority of these cases will have one, and only one provider, in place so that we can team cases easily, reduce confusion for families, and more meaningfully track outcomes by provider.

10. What about emergencies with Family Preservation Services cases?
    A: The Provider must provide intensive safety planning and crisis response services 24 hours a day/7 days per week/365+ days a year. This is a requirement of both their contracts and the program Service Standards.

11. What about existing IAs and In-Home CHINS cases? Will they automatically go to Family Preservation Services on June 1, 2020? And, if they do, how do you determine to which agency the referral is sent?
    A: This will be decided on a case-by-case basis with one of the primary things considered being how long the existing services have been in place and how the family is responding to them. If it's a newer case there is a much greater chance that we would want to shift the family to Family Preservation Services. The Child and Family Team who best knows each case would decide to whom the referral for FPS would be sent, if it is decided to shift an existing case to FPS.

FREQUENTLY ASKED QUESTIONS

12. How will I know, specifically, what service the family is receiving, and who's getting what?
    A: Providers, per their contract and per the FPS Service Standards, must complete their initial assessment and treatment plan within 7 days of their first contact with the family. This assessment will include their clinical impressions and their recommended interventions based on the family's presenting problems. Every month their Treatment Plan will be updated in their monthly report (there will be ONE monthly report for each case making it easier for the Court and DCS to know how the family is responding to the services), and, if a provider feels that they need to make a significant change in how they are treating the family, they must notify DCS who can inform the court.
    The providers under contract have expertise and the ability to deliver evidence-based models (there were 114 total different evidence-based practices submitted in providers' proposals), and they must deliver their chosen model(s) to fidelity as per their contracts and the Service Standards. They must also have a Continuous Quality Improvement (CQI) process built into their services which DCS will be monitoring, which is also a requirement of their contracts.
    Each family referred for FPS will have a weekly, in-home and face-to-face safety assessment that includes seeing each child and every caregiver and assessing the entire home for safety. If any safety concerns are noted, or if a family fails to be seen in a given week, the provider must *call* DCS and speak to someone. They cannot just leave a message, so, if no one is available at the local office, they must call the Hotline.
    (* please see question #16 for information as to how COVID-19 may impact the weekly in-home safety assessment)

13. Is a referral for family preservation under an IA just an assessment, or, are these specific services?
    A: Both IAs and In-Home CHINS cases will receive the same robust services (and the same per-diem reimbursement), which includes the initial assessment, safety plan, and treatment plan within 7 days of the first provider contact with the family. This will include the clinical impressions the provider has of the family, and their planned interventions (which will be evidence-based practice and concrete supports for families if necessary to prevent removals). In addition, all cases (IAs and in-home CHINS) will receive the at-least-weekly safety assessment for the duration of the case (and cases will last until either they are successfully closed or the child has to be "formally and indefinitely removed"). In addition, all caregivers involved with every case will be given the Protective Factors Survey within 30 days of receipt of the FPS referral, and every 3 months thereafter for as long as the case is open. This survey targets the acquisition and development of protective factors that we know through research help to keep kids safe. Lastly, every case will have one comprehensive monthly report detailing the treatment goals, interventions delivered, the family's response to those interventions, as well as documentation of any concrete supports provided to the family.
    (* please see question #16 for information as to how COVID-19 may impact the weekly in-home safety assessment)

FREQUENTLY ASKED QUESTIONS

14. How are you going to make sure families don't have to wait to get engaged with services?
    A: Prior to Family Preservation Services with the fee-for-service approach, families would often have to wait weeks or longer for their first appointment with a service provider. With FPS, providers can begin receiving the daily reimbursement once they have made their first contact with the family, thus incentivizing them to get out to the family's home as soon as possible so that they can begin receiving reimbursement. Then, within 7 days of that first contact, they must have their initial assessment, safety plan, and treatment plan completed which will help families to get engaged in their services quickly, which, we know through research, predicts better engagement in their services, and, thus, better outcomes. Providers must accept or reject a referral for FPS within 48 hours, and, as soon as they accept it, they will be eager to have their first contact in order to begin receiving reimbursement, which will continue to be provided every day after that until the case either successfully closes or the child(ren) have to be formally and indefinitely removed from the home.

15. We are talking about keeping children in homes with caregivers even though we know the vast majority of these cases will have had a substantiated abuse or neglect allegation. How are you going to keep those kids safe?
    A: Assessing safety will be an intentional and continuous focus of these services. Providers must, with DCS and the family's involvement, develop their initial safety plan within 7 days of their first contact with the family. The safety plan must also be continuously updated and modified as they learn more about the family. In addition, all cases (IAs and in-home CHINS) will receive the at-least-weekly safety assessment for the duration of the case (and cases will last until either they are successfully closed or the child has to be "formally and indefinitely removed"). If any safety concerns are noted, or if a family fails to be seen in a given week, the provider must *call* DCS and speak to someone. They cannot just leave a message, so, if no one is available at the local office, they must call the Hotline.
    (* please see question #16 for information as to how COVID-19 may impact the weekly in-home safety assessment)

16. How does COVID-19 impact these services?
    A: Indiana continues to be in a Public Health Emergency that was established by declaration of Governor Holcomb. As a result of this, depending on any presenting COVID-19 concerns within a referred family, the weekly in-home safety assessment where every child and every caregiver is seen face-to-face and the entire home is reasonably assessed for safety every week may look different from how it is written in the Service Standards. For example, we wouldn't want a provider to go into a home and see a caregiver face-to-face who is known to be COVID-19 positive. Therefore, specific Child and Family Teams involved in each case must work together to discuss how services will look for each case, balancing COVID-19 risks with child-safety ones. That said, providers were told that if they want to be eligible to receive FPS referrals during the public health emergency, they must be willing to complete at least some face-to-face visits in family's homes so that we can monitor child safety.

FREQUENTLY ASKED QUESTIONS

17. Is DCS really not going to remove ANY children?
    A: Of course some children will still have to be removed from their homes if the safety concerns present are too significant to be mitigated through the provision of these services. We do know, however, that we should be very thoughtful before intervening with families to that degree as we know, through research, that children are harmed when they are removed. We must weigh the risk of *possible* harm from keeping the child in the home with the *certain* harm caused when we remove.

18. Aren't families just going to take advantage of providers when it comes to concrete assistance? Aren't they just going to choose to not pay their rent or utilities to make the provider have to pay them?
    A: These concrete funds shouldn't be viewed as an entitlement, but, rather as a last resort to prevent having to remove children due to their basic needs not being met. Providers should work with families on budgeting early in their involvement with each family, and help them to apply for entitlements such as TANF, SNAP, and Medicaid that can remain in place after the DCS case closes. In an emergency, like a job loss resulting in the gas to the home being disconnected in the winter, the provider should work to connect the family to community resources like the Trustee's Office, the faith community, 211, etc., so that the family learns about these resources so they are better prepared if they encounter a similar circumstance after their DCS case has closed. Providers supplying concrete supports to families should be a team decision, and done as a last resort to prevent removals.

19. Those other states who have a lot fewer kids in foster care, don't they have really high rates of child fatalities?
    A: No. Per the Child Welfare Policy and Practice Group assessment of DCS in June 2018, only Arkansas, Mississippi, and West Virginia reported higher rates of abuse and/or neglect related child fatalities than Indiana.

20. What if there's a sibling group in the home, and one of the kids is removed for some reason. Would that end the referral for Family Preservation Services?
    A: No. The referral and services would remain in place for the family with the goal of preventing the removal of the other children. The FCM would have to issue a new referral reflecting the change in the number of children as the per diem amount may be impacted, but, services would continue. In addition, if the child returns, they can be added back to the referral with the per-diem amount potentially increased due to the addition of the child back into the home. The same would be true if the family has a newborn who becomes formally involved in the case (i.e., added to the CHINS case or IA agreement).