# CONNECTICUT COMMUNITY KIDCARE EVALUATION

## PHASE ONE

## Implementation Analysis of the Emergency Mobile Psychiatric Services (EMPS) and Care Coordination Programs

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The Human Services Research Institute
The Technical Assistance Collaborative

The Child Health and Development Institute of Connecticut, Inc.

**Prepared by:**
John O Brien, M.A.
Senior Consultant
Technical Assistance Collaborative, Inc.

Virginia Mulkern, Ph.D.
Senior Vice President
Human Services Research Institute

Steve Day, MSW
Executive Director
Technical Assistance Collaborative, Inc.

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# EXECUTIVE SUMMARY

## IMPLEMENTATION ANALYSIS OF THE EMPS AND CARE COORDINATION PROGRAMS

In January of 2002, the Department of Children and Families (DCF) designed and implemented two new major initiatives for youth and caregivers as part of the Connecticut KidCare Initiative: Emergency Mobile Psychiatric Services (EMPS) and the Care Coordination program. EMPS provides clinical interventions, case management, and supports necessary to successfully stabilize and maintain children in their home or community. The primary focus of EMPS is the prevention of hospitalization and out-of-home placements. Care Coordination services are provided to eligible youth who have complex service needs especially youth who are at imminent risk for residential or hospital levels of care or who are returning from those levels of care. As of April 1, 2003, 2579 children/youth had been served by EMPS programs and an additional 464 children/youth have been served in Care Coordination.

DCF contracted with the Child Health and Development Institute of Connecticut, Inc (CHDI) to conduct a comprehensive evaluation of the Connecticut Community KidCare Initiative. CHDI contracted with the Human Services Research Institute and its partners, The Technical Assistance Collaborative and the University of South Florida to carry out the evaluation. This substudy reports data from an in-depth analysis around the implementation and operation of the Emergency Mobile Psychiatric Service (EMPS) and Care Coordination (CC) initiatives. The goals of this analysis were to:

- Assess the degree to which EMPS and Care Coordination programs adhere to the intent of the procurement and whether key implementation steps have been achieved;

- Identify factors that both facilitated and were barriers to implementation, especially information that can be used to foster replication and to make future implementation efforts more efficient. This included environmental factors that influenced the implementation process, and also could influence the attainment of desired outcomes; and

- Identify implementation issues that may require adaptation of the original design to meet current and changing local conditions.

A qualitative approach for this analysis was used and included program site visits, interviews with key informants at the state and regional levels (including youth and families who used the service) and document reviews.

**Adherence to the Intent of the Procurement**
DCF has contracted with eleven agencies to provide a statewide network of emergency mobile crisis services and care coordination. The analysis indicated that EMPS and Care

Coordination contractors met critical requirements set forth in the contract. Major achievements since the beginning of these programs include:

- All EMPS programs have a local toll-free number that is staffed 24 hours a day/365 days a year for youth experiencing a behavioral health crisis.
- All EMPS programs have mobile capacity during the required hours of 10:00 AM to 7:00 PM weekdays, and 1:00 PM to 7:00 PM on weekends and holidays. Over one-half of the EMPS programs provide mobile capacity for additional hours.
- Almost all EMPS and Care Coordination programs are fully staffed and have staff that are fluent in prevalent languages, especially Spanish.
- All EMPS and Care Coordination providers are collecting and reporting critical data to DCF.
- EMPS teams and Care Coordination programs were at capacity at the time of this review. Most care coordinators caseloads did not exceed the maximum of 1:12.

However there were significant concerns regarding the following:

- Lack of crisis plans for EMPS and Care Coordination contractors. Less than 25 % of records reviewed contained a crisis plan or safety plan.
- Progress notes for youth involved with EMPS lacked specific details of the precipitating crisis, crisis intervention, and follow-up care.
- Documentation for eligibility for Care Coordination services was present in less than 50% of all records reviewed. Fewer than 10% of all records identified the reason for the child/youth being eligible for this service.
- There was no consistency regarding parent/caregiver signature on the assessment, individual service plan, or crisis plan.
- EMPS programs memoranda of understanding (MOUs) with local hospital emergency departments (EDs) were weak the MOUs did not delineate clear roles and responsibilities between the ED and the EMPS provider.

**Factors that Facilitated Implementation**

All interviewees were asked to identify the state and regional factors that enhanced the implementation of the EMPS and Care Coordination Programs. The respondents indicated that the following factors have positively influenced these programs implementation:

- Prior history of providing the services: Agencies that had a prior history of providing emergency or care coordination services had the existing infrastructures that allowed for timelier start-up.
- KidCare Training: Care coordinators participated in the KidCare Training enhancing the service planning and delivery process and use of natural and community supports.
- Staff Attitudes: EMPS and Care Coordination staff were often involved in the design and implementation of the program, allowing staff to have significant ownership in the success of the program.
- Uniform Client Record: Care Coordination program managers considered the Uniform Client Record (UCR) a useful tool for collecting and organizing

information. The UCR also provided uniformity regarding the format of the assessment and service plan.

- Community Collaborative involvement: Care coordinators identified that Community Collaborative members played a significant role in identifying and developing resources that were helpful not only to a specific child or youth but to other children.
- Existing relationships between providers: Agencies that received EMPS and Care Coordination contracts identified local provider network support as a factor that facilitated implementation allowing for strong collaboration and referral agreements between agencies.

**Implementation Barriers**

The analysis identified several barriers that adversely impacted the implementation of the EMPS and Care Coordination programs. These barriers have limited EMPS contractors ability to divert children from hospital emergency departments and inpatient psychiatric units. Youth continue to wait for days in an emergency department for an available inpatient bed. These barriers have also hampered Care Coordination programs efforts to successfully locate and facilitate linkage with much needed behavioral health treatment and supports. These barriers include:

- Lack of access to community services for children and adolescents and their families. This lack of access to community services was reported to contribute to the long lengths of time necessary to resolve many crisis situations, and may also be related to the inability to prevent or divert some inpatient admissions. Care coordinators were also likely to hold on to cases longer than would otherwise be necessary because of the lack of services.
- Difficulties in recruiting (and in some cases retaining) appropriate staff for the EMPS program including licensed clinicians and other staff that had experience in providing crisis services to youth, willing to work evenings, weekends and be on-call.
- Confusion regarding who is responsible for providing and, in some instances, eligible for receiving mobile crisis response services, especially youth who are served by other behavioral health professionals or agencies.
- Federal regulations that require emergency departments to provide medical screening examinations within the emergency department rather than referring to a community crisis program for triage, assessment and stabilization.
- The EMPS program is not funded sufficiently to provide mobile response capacity after certain hours. Therefore, the historical patterns of referrals to police and EDs continue when mobile response is not available.
- Care coordinators are not clear about the utility of the time-limited care coordination model. They cite the chronic nature of serious emotional disorders as a reason why time-limited care coordination is inappropriate.
- Community Collaboratives are having a difficult role transition, resulting in confusion about the collaborative s role and some degree of dissatisfaction among collaborative members.

- Many contractors and care coordinators believe that there is a pervasive lack of understanding of KidCare within DCF. They believe that many DCF workers have not gotten the message and do not yet subscribe to the family empowering component of KidCare.
- There is some lack of clarity about the family advocate s role in the care coordination process.

**Issues Requiring Further Analysis and Discussion**

As the EMPS and Care Coordination program enter their second year, there are several issues that the Department should address to enhance the effectiveness and outcomes of these programs. These issues reflect changes that should be considered for the Connecticut KidCare program and programmatic changes specific to the EMPS and Care Coordination program. Several of these issues can be resolved with additional clarification of intent and policy. Other issues will require long-term strategic solutions and resources.

**System Changes**

- Improving EMPS relationships with hospital emergency departments: Better memoranda of understanding need to developed and implemented. DCF may also want to consider a committee (EDs, EMPS contractors, DSS and DCF) to develop strategies for resolving current and ongoing implementation issues between EDs and EMPS. This should be the Department s priority for the next year to address the admissions into emergency departments and inpatient psychiatric services.

- Service availability: The lack of available services will affect the integrity of the EMPS and Care Coordination models. Several EMPS programs are serving youth well past eight weeks (and Care Coordination programs past six months) when the appropriate transition treatment and supports are not available. The most often needed services include: mental health counseling, school intervention, mentoring, extended day treatment and in-home services.

- Workforce issues: EMPS and Care Coordination will continue to face many workforce challenges. DCF must develop recruitment strategies to ameliorate these issues in the future.

**EMPS and Care Coordination Program Changes**

- Clarifying eligibility for EMPS and Care Coordination services: This may be corrected through issuance by DCF of policy guidance. Such guidance should be circulated or publicized to all other providers and DCF programs, to assure that knowledge and expectations related to priority access to EMPS mobile services are clear to all parties. It is particularly important to clarify eligibility guidelines for utilization of EMPS services by schools. The Department should immediately develop policies that clarify the eligibility for this program and ensure that EMPS and Care Coordination contractors are informed of these criteria. DCF as well as

the EMPS and Care Coordination contractors should disseminate this information to local communities through their ongoing marketing efforts.

- Ongoing assessment of EMPS and Care Coordination program models: As with any newly developed program, it is important that DCF regularly reassess the program models to insure that both program administrators and staff are clear about the programs intents. This includes clarifying: the program goals and objectives, the expected sequencing of activities, and the types of activities that fall within and outside of the program models.

- Service documentation: EMPS and Care Coordination staff need guidance regarding their documentation regarding service and crisis plan development. Lack of clear documentation raises significant clinical liability issues for these programs.

- Staff safety: DCF should work with EMPS and Care Coordination contractors to develop appropriate assessment and response to minimizing staff risk when providing services in home and other settings. DCF may wish to work with representative EMPS programs to develop standard risk assessment and management protocols, and to circulate training materials based on these safety protocols for inclusion in EMPS staff orientation and training activities.

- Evaluation of Care Coordination: Further evaluation of the Care Coordination model should be considered to determine whether effects achieved during the care coordination period are maintained over time. That is, do the community services packages that are implemented through the Care Coordination program survive and evolve as the child ages, experiences changes in needs and as staff in community programs turn over. Also important is the degree to which parents learn to advocate for themselves and their child as needs evolve over time. The current evaluation of the KidCare Care Coordination program is a start. However, this substudy is primarily examining the process of care coordination. It has not been designed to analyze the longer-term effects. It may be possible to build this element into successive years of the evaluation. Future evaluation efforts should also assess issues related to length of stay and the degree to which the children and families who receive Care Coordination services meet established eligibility criteria.

- Further evaluation of the EMPS model: DCF should consider additional evaluation of the EMPS model and the possibility of providing sufficient incentives for EMPS to assess and divert children from EDs and inpatient behavioral health services. The evaluation should also focus on whether the current hours of operation provide appropriate and sufficient coverage for youth and families who are in crisis when mobile capacity is not available (nights and significant parts of the weekend).

# CHAPTER 1: OVERVIEW

The purpose of the implementation analysis is to document whether the Department of Children and Families (DCF) Connecticut Community KidCare Initiative was implemented as planned. The approach to the implementation analysis includes four dimensions: (a) analysis of initial implementation activities; (b) collection of baseline data; (c) measuring changes from baseline to the present; and (d) changes in the interactions and resultant policies among child serving agencies at the state level. The first two dimensions were included in Phase I of the implementation analysis.

In the Phase I study, an in-depth analysis was conducted of the implementation and operation of the Emergency Mobile Psychiatric Service (EMPS) and Care Coordination (CC) initiatives.

The goals of the Phase I implementation analysis were to:

1. Assess the degree to which EMPS and Care Coordination programs adhere to the intent of the procurement and whether key implementation steps have been achieved;

2. Identify barriers and other factors that facilitated implementation, especially information that can be used to foster replication and to make future implementation efforts more efficient. This included environmental factors that influenced the implementation process, and also could influence the attainment of desired outcomes; and

3. Identify implementation issues that may require adaptation of the original design to meet current and changing local conditions.

**Methodology**

The primary data sources for the implementation analysis were key informants at the state and regional levels. Key informants included state, regional and local stakeholders who are responsible for funding, planning, implementing, managing, and evaluating the KidCare initiative. In addition, the review team conducted site visits to each of the EMPS and Care Coordination contractors and subcontractors. During these site visits, the review team reviewed records, policies and procedures, and other key documentation that is necessary to the operation of these programs.

*Site Visits and Interviews*

For the purpose of this analysis, each of the EMPS and Care Coordination programs that were in operation more than six months received a site visit. Sixteen EMPS and Care Coordination contractors and subcontractors were visited. Interviews were conducted between November 2002 and January 2003. Interviewees included executive directors, EMPS and Care Coordination program managers, and staff that provide emergency services and care coordination. Approximately 38 EMPS and Care Coordination staff were interviewed.

Staff from each DCF region were also asked to participate in the interviews. Eight DCF regional staff (representing four of the five regions) with direct responsibility for overseeing the EMPS or Care Coordination contracts participated in these interviews.

This analysis also sought to collect preliminary information from individuals that were primary and secondary users of EMPS and Care Coordination services. Primary users included individuals and families that had received either service. Secondary users included agency representatives who either referred individuals to these services or received referrals from these programs. EMPS and Care Coordination contractors arranged interviews with families that were currently or had previously received either EMPS or Care Coordination services. Eighteen family members were interviewed for this analysis.

Regional DCF representatives were asked to identify providers that have referred or received referrals from EMPS and Care Coordination programs. Several representatives from hospital emergency departments were specifically requested to participate in these interviews. Hospital emergency departments were intended to work closely with local EMPS programs to divert children and adolescents from inpatient psychiatric services. Twenty three providers participated in these interviews, including five interviewees from hospital emergency departments.

Regional DCF family advocates were also interviewed. Family advocates play a critical role in assisting parents to engage and develop skills to coordinate care for their children and adolescents. Five family advocates representing four of the five regions were interviewed for the implementation analysis.

Local Community Collaborative representatives have a critical role in the implementation and ongoing operation of the EMPS and Care Coordination programs. Each EMPS agency is required to actively participate in the local collaborative. In many instances, representatives from the Community Collaborative were involved in DCF s previous Care Coordination efforts, actively participating in coordinating care for individual youth and their families. Sixteen Community Collaborative representatives participated in the interviews.

Attachment #1 includes the interview protocols used for the interviews.

*Analysis of Key Documentation*
In addition to the formal interviews with key informants, the analysis reviewed documentation associated with the project. The documents included information on:

- *Program operations*: Information on the placement of the EMPS and Care Coordination programs in the agency, hours of operation, staffing patterns, credentials, clinical protocols, subcontracts with agencies providing these services, staff cultural competency, and other information essential to operating these programs.

- *Service documentation:* A review of records to determine if records were present for a sample of individuals participating in the EMPS and Care Coordination program and the extent to which documentation indicated:
    - Whether these services were appropriate. For instance, was documentation present that indicated that a child met criteria for Care Coordination (e.g. Level III)?
    - Whether families were included in the assessment and service planning process.
    - Whether crisis and safety plans were present for children, adolescents and families who participated in EMPS and Care Coordination.

  When possible, each contractor and subcontractor was requested to provide a random sample of records (selected by the review team).
- *Agencies policies and plans:* Policies of concern included staff safety, critical incidents, release of information and protocols for contacting family members, the police, and others in case of an emergency or critical incident.
- *Community participation:* (especially for EMPS) this included a review of EMPS staff participation in the Community Collaboratives and plans for community education that included schools, pediatricians, hospitals, and health facilities. In addition, this review focused on the mandatory memorandum of understanding (MOU) between each EMPS program and local hospital emergency departments.
- *Encounter reporting processes:* Review of procedures that providers had in place to report information to DCF regarding client enrollment, encounters, outcomes, financial and other data.

Attachment #2 provides a list of information requested from each EMPS and Care Coordination contractor and subcontractor.

# CHAPTER 2: ADHERENCE TO THE INTENT OF THE PROCUREMENT

One of the major objectives for the implementation analysis was to determine the extent to which EMPS and Care Coordination programs adhered to the intent of the procurement and whether DCF and their contractors performed key implementation steps. The EMPS and Care Coordination solicitation and contracts were reviewed to identify critical program components and implementation steps that would be used for interviews and site visits. These critical components included program operations, documentation, staffing and staff development, community participation, agency policies and plans, community participation, and encounter reporting. These components were included in a checklist that was used by the analysis team for each contractor and subcontractor. The following provides an overall analysis of contractor s efforts to implement these programs.

***Emergency Mobile Psychiatric Services***

*Overview*

Emergency Mobile Psychiatric Services (EMPS) provide clinical interventions, case management, and supports necessary to successfully stabilize and maintain children in their home or community. The primary focus of EMPS is to prevent hospitalization (unless clinically necessary) and out-of-home placement. EMPS provides a consistent, local point of access for children/youth that are in crisis and provides immediate, mobile care at the site of the crisis by qualified mental health professionals. EMPS provides short-term clinical interventions as well as immediate access to a range of complementary services, including: next-day behavioral health crisis appointments; medication assessment and management; and in-home therapeutic and stabilization interventions.

The target population is any child or youth in crisis including any HUSKY A or B or Voluntary Services program enrollee and any other child or youth experiencing an acute crisis. The EMPS service is available across child welfare, juvenile justice, prevention and behavioral health systems including: children residing in relative, adoptive and foster care homes and children residing in congregate care settings including emergency shelters, group homes and SAFE homes. For children currently involved in clinical treatment, the EMPS first assesses the capability of that treatment provider to handle the intervention.

*Program Operations*

All EMPS programs are required to have a number of operational factors in place. These include:

- A local toll-free number that is staffed 24 hours a day 7, days a week;
- Marketing materials that advertise this toll-free number; and
- EMPS marketing materials in languages that are prevalent in local communities.

The analysis indicated that all EMPS programs met these requirements. All EMPS programs had an established toll-free number and had marketing materials (e.g. posters, pamphlets, magnets, balloons) providing this information. All but one program had

developed and disseminated EMPS marketing materials in languages that were prevalent in the local community. The analysis team called several toll-free numbers at different times (evening and weekends). Each EMPS program that was called had staff that answered the phone within 3-5 rings (within acceptable industry standards).

EMPS programs are required to have mobile capacity to perform a face-to-face crisis assessment on weekdays between 10 A.M. and 7 P.M. and on weekends and holidays between 1 PM and 7 PM. EMPS staff are expected to perform a phone assessment within 15 minutes and/or perform a face-to-face assessment (if necessary) within 30 minutes of receiving a crisis call. Almost all EMPS programs (92%) met or exceeded hours of mobile capacity as set forth in their contracts. More importantly, over one-half (54%) provided mobile capacity for additional hours/days. It was difficult to determine if EMPS contractors met the 15- and 30-minute standards for phone and face-to-face crisis assessments. In most instances, this information is not automated or tracked in a manner that accurately provides the time of the call and the time of the response.

EMPS programs are also required to have protocols that identify whether a caller is in crisis and whether immediate access to EMPS teams and clinicians is necessary. These protocols are to guide staff on the use of on-call psychiatrists, when to facilitate an acute care admission to a psychiatric unit and post-crisis decision points, including referral to transition services and case closure. Most EMPS programs (83%) had defined clinical protocols for screening and triaging EMPS callers. These protocols identified whether the situation was:

- Emergent and would require an immediate telephonic or face to face visit and intervention;
- Urgent and would require an assessment and/or intervention within the next 24 hours; or
- Routine and would not require an intervention from EMPS but required some mental health services (e.g. counseling).

Industry practice requires mental health crisis programs to have clinical protocols that staff use to determine the appropriate intervention strategy. Clinical protocols used by many EMPS programs had established decision trees for interventions if one or more of the following were present:

- Suicidal ideation
- Homicidal ideation
- Change in mood or behaviors (agitation/depressive symptoms)
- Presence of aggressive behaviors

In addition, these EMPS programs had identified crisis assessment and resolution strategies for immediate involvement of police or the Department of Children and Families.

*Documentation*

EMPS providers are required to have an individual record for each child and adolescent who receives crisis services. There are several key pieces of information that are

required in each EMPS record. For instance, each child or adolescent is required to have a completed crisis plan and a follow-up plan. In addition, progress notes for each assessment, intervention and ongoing treatment by staff from EMPS are required to be in the record.

The team requested each EMPS contractor to provide 5 records for the purpose of this review. The analysis team requested records through a pre-established random selection process.[1] For EMPS programs that provided records based on a random review, a record existed for each child or adolescent selected. All records reviewed contained information obtained from a crisis assessment and a signed release of information from the parent or caregiver. However, less than 25 % of records reviewed contained a crisis plan or safety plan. Interviews with EMPS clinicians suggested that many were confused about the purpose and format of the required crisis/safety plan. In addition, progress notes lacked specific details of the precipitating crisis, crisis intervention, and follow-up care. For recipients receiving extended EMPS, services were not well documented. This lack of documentation presents various clinical and financial liabilities. For instance, it was not easily discernable whether an individual was in crisis and whether the proposed intervention (e.g., telephonic versus face-to-face assessment) was warranted.

*Staffing and Staff Development*

All EMPS providers are required to develop a table of organization that clearly delineates the role of the EMPS program in the overall agency structure and staffing schedules for the EMPS program. The table of organization provides some assurance that EMPS staff have clearly delineated responsibilities, levels of authority, and the presence of a clear decision-making chain of command within the agency and EMPS program. In addition, contractors are required to have the following staff for the EMPS program:

- Clinical Director/Team Leader
- Comprehensive Care Manager
- Service Effectiveness Coordinator
- Psychiatrist
- Administrative Assistant/Data Manager
- Crisis Staff

The psychiatrist and clinical director are required to be licensed as mental health practitioners by the state of Connecticut under the appropriate practice act (psychiatry, psychology, etc.). The EMPS agency is responsible for credentialing each licensed staff and ensuring that one or more EMPS staff are fluent in a language other than English. In addition, each EMPS contractor is required to have a staff development plan and training schedule. The staff development plan must include training regarding mandated reporting, blood born pathogens, de-escalation management techniques and KidCare Practice Standards for System of Care.

[1] In some instances, the records provided by the EMPS provider were based on records for which families had a signed release of information form rather than random selection.

The review of documentation provided by EMPS contractors indicated that all but one EMPS program had a clearly defined role in the organization table for the agency. All EMPS programs had job descriptions for required staff and had a written credentialing policy for EMPS licensed staff. In addition:

- All EMPS programs had staff fluent in prevalent languages, especially Spanish. EMPS teams had staff that were bi/multi-cultural and bilingual or had a contract with interpreters for non-English speaking families.
- Specific staff development plans were present for all contractors for 2002. However, only 54 % of the EMPS programs had training plans for calendar year 2003.
- Almost two-thirds of the EMPS programs development plans indicated training on mandated reporting, blood-born pathogens, crisis management techniques, and the Practice Standards for Systems of Care.

*Agency Policies and Procedures*

In addition to the protocols for assessing and triaging children and adolescents in crisis, EMPS contractors are required to have other policies for delivering crisis services. These policies include:

- Written protocols for contacting the police, family members and others in an emergency situation.
- Safety policies that provide specific guidance to EMPS staff who meet with youth and families in a variety of settings including the office, home, and hospital emergency department. These policies provide specific procedures for staff to assess the situation beforehand to determine whether there is potential for a dangerous situation and to make the necessary modifications in the intervention to address these concerns.
- Policies regarding the use of physical behavioral interventions for youth.
- Explicit forms and policies regarding release of information.
- Protocols for reporting critical incidents.

Each EMPS program s policies and procedures were reviewed for these critical elements. In addition, program managers and staff were interviewed regarding staff safety and use of physical behavioral intervention to identify the extent to which staff were informed of and adhered to these policies. The review indicated that all EMPS agencies had policies and procedures regarding the use of physical behavioral interventions. These policies explicitly stated that staff do not perform physical restraints, therapeutic holds, or mechanical restraints of clients.

In addition, two-thirds of EMPS programs had specific policies for staff safety. In follow-up interviews, less than one-half of the interviewees were aware of these policies, although most indicated they had developed an approach for delivering crisis services that included staff safety.

All EMPS programs had explicit forms and policies regarding release of information and had forms and protocols for reporting critical incidents and special issues. A review of

the youths records indicated that all records reviewed did have one or more signed releases of information.

*Community Participation*
EMPS programs are expected to develop partnerships and relationships with community organizations that are likely to provide services to youth and families who are in crisis or at high risk of crisis. Each EMPS agency is to develop a memorandum of understanding (MOU) with local hospital emergency departments (EDs). This memorandum of understanding is to delineate the roles and responsibilities between the ED and the EMPS provider regarding referrals, assessments, and interventions for children/youth in crisis.

EMPS programs are also required to provide outreach and education to parents, family advocates, Community Collaboratives, schools, police, juvenile courts, health clinics, pediatricians, and local offices of DMR, DSS and DMHAS. In addition, lead staff (usually the clinical/program director) from each EMPS program are required to participate in the local Community Collaborative. These staff are required to attend each collaborative meeting.

The review team found that all EMPS programs had memoranda of understanding with at least one local hospital emergency department. However, the terms and conditions of these MOUs varied tremendously across programs. For instance, some MOUs were really letters of support that were submitted with the EMPS proposal. Other MOUs did not delineate clear roles and responsibilities between the ED and the EMPS provider. For instance, they did not contain clear language regarding the willingness of the ED to allow EMPS staff to participate in clinical assessments to determine whether the youth should be admitted for inpatient care or could be referred to EMPS and intensive outpatient community mental health services. Most MOUs did state that the ED would be willing to refer individuals to EMPS, but were not clear regarding the referral process.

One-half of the EMPS programs had a specific and timely plan for community education and outreach. Most EMPS programs had initiated these plans within the first three months of operation. Program directors indicated that these outreach efforts increased the awareness of the community regarding these services and also increased the volume of referrals immediately, ensuring that the EMPS teams were at full capacity. Individuals interviewed indicated that schools provided the greatest volume of referrals. An analysis of referral information from EMPS programs indicated that approximately 42-65% of all referrals were from schools during the first six months of the EMPS program.

Information collected from interviewees (program staff and representatives of the collaboratives) and meeting minutes indicated that almost all (93%) of EMPS clinical directors or senior staff members regularly participated in Community Collaboratives.

*Encounter and Data Reporting*
The EMPS contractors are required to develop a data collection system that provides an accurate, unduplicated count of children/youth and families receiving EMPS services. Specifically, each EMPS contractor is to provide:

- Client enrollment data (e.g., demographics, educational/vocational, family status/living arrangements).
- Service encounter data (e.g., service utilization, availability of services).
- Clinical data (e.g., diagnosis, medications).
- Client outcomes (e.g., functioning, symptom relief, consumer perception, cultural competency).
- Financial data (e.g., payers, expenditure profile).
- System Performance Indicators (e.g., access, quality, appropriateness, site and mode of service).

The EMPS programs are required to develop and implement a process for submitting these data to DCF (including information from any subcontractors) in the format and the timeframes requested by the Department.

The team assessed the EMPS encounter and reporting process. This review indicated that all EMPS providers had protocols for collecting this information at the initial point of contact. For instance, program intake and initial assessment collected information on demographics, family status/living arrangement, payer information and clinical data. In addition, the intake and assessment also collected information that could be used to track client outcomes (e.g., level of functioning, etc.). However, it was not clear from this review which information was collected and entered on a timely and consistent basis initially for EMPS programs. In July of 2002, DCF required these programs to report data to DCF using a specific file format.

**Care Coordination**

*Overview*

Care Coordination services are provided to children and youth enrolled in HUSKY Part A and Part B and DCF s Voluntary Services Program who have complex service needs and require Level III Care Coordination. Level III Care Coordination is a critical component in the KidCare framework. This level of Care Coordination is associated with intensive service provision over and above any other behavioral health treatment or support service that the child and family may be receiving. Care Coordination services are also available to other children and youth with complex service needs with priority given to those children and youth who are at imminent risk for residential or hospital levels of care or who are returning from those levels of care. Since the implementation of the Care Coordination program through the end of April, 2003, 464 children/youth have been served in Care Coordination.

Each Care Coordination contractor is responsible, either directly or through a subcontract arrangement, to manage and supervise the work of the care coordinators. The specific responsibilities of the care coordinators include:

- Assisting the family to develop and convene a Child Specific Team;
- Developing and implementing an Individualized Service Plan for each child;
- Weekly in-person and/or phone contact with each family;

- Maintaining a Uniform Client Record on all children and families;
- Developing service and support plans for each family that offers guidance for traditional and crisis response services as well as non-traditional opportunities; and,
- Working collaboratively with DCF social work staff to ensure a consistent informed case management plan.

*Program Operations and Staffing*
Each Care Coordination contractor must have a clear table of organization that identifies where the Care Coordination program fits in the overall agency structure and that identifies the reporting structure within the Care Coordination program. Similar to EMPS, the table of organization for Care Coordination is meant to ensure that staff have clearly delineated responsibilities, levels of authority, and the presence of a clear decision-making chain of command within the agency and the program.

In addition, each contractor must have job descriptions for Care Coordination and ensure that Care Coordination staff meet the credentials set forth by the contractor for this position. Unlike EMPS, DCF did not specify the credentials for Care Coordination staff. However, DCF did require that Care Coordination staff must be fluent in prevalent languages. Contractors were to establish the credentials and a process for pre-employment screening (e.g., criminal record and protective services history) and for reviewing the credentials established in the job description (e.g., presence of a bachelor s degree and/or sufficient work history, languages spoken). Finally, DCF required that each care coordinator s caseload must be no higher than 1 caseworker to 12 children or youth.

The table of organization for each Care Coordination contractor and subcontractor, job descriptions and staffing were reviewed. This review indicated that:

- All Care Coordination programs had clearly defined roles in their agency s table of organization. In addition, each Care Coordination program had a clear internal reporting structure with supervisory and oversight responsibility within and among Care Coordination subcontractors.
- All Care Coordination programs had job descriptions for required staff.
- Eleven of fifteen Care Coordination contractors or subcontractors (72%) had an internal credentialing process to determine whether staff met the credentials set forth in the job description. A review of the staff s resumes and documented credentials for a sample of agencies found that all staff met or exceeded the credentials. All care coordinator contractors and subcontractors had at least one staff member who was fluent in prevalent languages. All contractors had a contract or agreement with interpreters for non-English speaking families.

Two-thirds of the Care Coordination programs were fully staffed at the time of this review. For those that were not fully staffed, only one position was vacant. In all but one instance, the position had been vacant less than 30 days. Almost all (92%) of the Care

Coordination agencies had caseloads that were 12 or less. The highest caseload reported was 1:20.

*Documentation*
Each Care Coordination contractor is required to collect information concerning the families and children/youth for which they are providing services using the Uniform Client Record (UCR). This information includes:

- Comprehensive Assessment. This initial assessment provides important demographic and clinical information as well as identifies services that may be needed by the youth/family. This assessment sets forth preliminary recommendations for service referral. Assessments are to be completed prior to the development of the Individualized Service Plan (i.e., within 30 days of the referral).
- Level III determination and referral. Care coordinators are required to identify whether an individual is eligible for Level III and identify the reasons the child/youth would require intensive Care Coordination.
- Individual Service Plan (ISP). Each child is required to have an Individual Service Plan that identifies goals, activities, timeframes, and individuals that are responsible for assisting the youth/child with specific activities in the plan.
- Individual Crisis Plan**.**
- Progress notes that provide information regarding the care coordinator s activities including: date and time of activity, and a description and purpose of the case coordination activity.

In addition, each Care Coordination contractor is required to obtain the parent/caretaker s signature on these documents. The presence/absence of the parent/caregiver s signature is one indication of the family s direct participation in crisis and service planning.

A review of child/youth records from each Care Coordination contractor and subcontractor was conducted. The process used to select and review the Care Coordination records was similar to the selection process for EMPS records. The analysis team requested records through a pre-established random selection process. Five records were requested from each contractor or subcontractor. For Care Coordination programs that provided records based on a random review, a record existed for each child or youth selected. The record review focused on the presence of critical information from the UCR. The review found that:

- All records reviewed had a signed release of information.
- Documentation for Level III eligibility was present in less than 50% of all records reviewed. When this documentation was present, fewer than 10% of all records identified the reason for the child/youth being eligible for Level III.
- A crisis plan was present for fewer than 40% of Care Coordination recipients.
- There was no consistency regarding parent/caregiver signature on the assessment, individual service plan, or crisis plan.

The review team also focused on whether there was any consistency between services that were requested and recommended at assessment and the services that were identified in the individual s service plan. The review indicated that:

- The assessment is intended to provide a menu of treatment and support services that are preliminarily recommended for the child or youth. However, our review suggested that services were not always identified in the assessment.
- The UCR provides the assessor the opportunity to identify the referral options for services preliminarily set forth in the assessment. However, for services that were identified in the assessment, very few referral sources were indicated on UCR.

Services in the ISP did not match services in the initial assessment. It was not the review team s expectation that all the services preliminarily identified in the assessment would be included in the ISP. A primary purpose of the Child Specific Team (which includes the parent/caregiver) is to review the assessment and collateral information and identify the services and supports that the child/youth and family need. However, there were significant discrepancies between what was initially recommended at assessment and what was included in the initial ISP. These inconsistencies imply that the service checklist in the UCR assessment document is not being used consistently across programs. In some instances, the checklist is used to indicate the past services received by the youth. In some, it is used to record all of the child s needs, whether these needs are currently being addressed or not. In other instances, it reflects only what the youth or family need prospectively. The inconsistency between assessment and the ISP may also reflect the differences between what the youth may need and the available supports and services in the community. Finally, the difference may reflect a better assessment of services by the Child Specific Team. In any case, the lack of consistency across sites means that these data are of little use in program management.

*Staff Development*

Each Care Coordination contractor, similar to EMPS, is required to have a staff development plan and training schedule. The staff development plan is to include training regarding mandated reporting, blood born pathogens, de-escalation management techniques and KidCare Practice Standards for System of Care. Care coordinators are also expected to participate in DCF s pre-service training. The review team found that all Care Coordination contractors and subcontractors had staff that participated in pre-service training. Newly hired care coordinators (those hired within the last 90 days) had not participated in the training, but were scheduled to participate in the next available pre-service training. Specific staff development plans for 2003 existed for 73% of all Care Coordination programs. All but one Care Coordination contractor had training on mandated reporting, blood born pathogens, de-escalation/crisis management techniques, and Practice Standards for System of Care.

*Agency Policies*

Care Coordination contractors are required to have critical policies and procedures regarding release of information, critical incident reporting, and protocols for contacting the police, EMPS, family members and others in an emergency or critical incident. Care

Coordination programs are also required to have policies for staff safety and a written grievance process. Since many of the Care Coordination contractors were also EMPS contractors, the review team s findings are consistent with the EMPS findings. The review team found that all Care Coordination contractors had explicit forms and policies regarding release of information. All agencies had written grievance policies. All Care Coordination contractors had forms and protocols for reporting critical incidents and special issues. Sixty percent of the Care Coordination programs had specific written policies for staff safety.

*Encounter Reporting*

Care coordination agencies are also required to develop the necessary infrastructures to collect and submit child/youth demographic, encounter and outcome information. The team reviewed the Care Coordination encounter and reporting process. This review indicated that all Care Coordination providers had protocols for collecting this information at the initial point of contact.

# CHAPTER 3: IMPLEMENTATION BARRIERS

EMPS and Care Coordination services have now been implemented in all DCF regions. Interviews with contractors, parents and area providers suggest that the programs are meeting important needs. According to Department of Children and Families statistics, over 2579 youth and their families received EMPS and 464 children and their families received Care Coordination services from the start of the programs through April, 2003. As with any new program, however, a number of barriers have emerged during the early implementation phase.

**Emergency Mobile Psychiatric Services**

*Staffing*

Most EMPS teams interviewed reported difficulties in recruiting (and in some cases retaining) appropriate staff for the mobile teams. It was reported that licensed personnel (primarily LICSWs) have been in short supply in Connecticut. This shortage has been compounded by competition among EMPS and Care Coordination contractors for the same limited pool of available licensed staff.[2] Hiring a large group of staff, all within the same time period, proved to be particularly difficult. These difficulties were multiplied substantially in the efforts to hire bilingual/bicultural staff and other licensed personnel meeting cultural competence criteria.

Some recruitment barriers appeared to be specific to the EMPS service. For example, it was reported that many licensed clinicians prefer to have an office-based practice during regular working hours. Thus, the availability of licensed personnel willing to work evening and weekend shifts, and/or willing to provide mobile, in-home services was more limited. Those licensed individuals willing to work nights and weekends and to provide mobile services tended to be less experienced than those willing to work during regular office hours. An exception to this recruitment barrier was some of the licensed crisis response staff that had previously been employed in DCF or DMHAS crisis service programs. These latter individuals had already opted for a professional model that included mobile outreach, in-home services and off-hours work activities.

*Staff Competencies*

The EMPS program is significantly different in scope from the previous DCF-funded crisis programs. The previous crisis programs budgets were small (often less that $50,000 annually) and consisted of a single clinician or several part-time staff who did brief assessments and referrals to ongoing treatment and supports. The mobility of this staff was limited and there was very little coverage during the evening and weekend. The EMPS program requires a very different staff skill set. Staff must be able to:

- Respond to a crisis within a very prescribed timeframe;
- Assess risk for suicide, homicide, psychosis and harmful behaviors;
- Work as a team (versus a solo practitioner);

[2] Competition among the EMPS and Care Coordination sites for these staff was reported. In addition competition for these staff from other sources, including DCF offices, was also reported.

- Develop and implement a crisis plan (versus brief assessment and referral to a community provider) and provide treatment and supports up to eight weeks; and
- Gain the trust of hospital emergency department staff, schools, families and community providers to allow assessment, diversion and ongoing treatment.

It was clear from the interviews that contractors had a very challenging time finding staff immediately with these competencies. This affected the ability of the EMPS contractor to hire staff on a timely basis (as discussed above), required more time initially to develop and implement a curriculum for training staff on key crisis response activities and also required more hands-on supervision of staff.

Some DCF EMPS contractors also provide crisis services for adults. These agencies experienced a quick implementation of the EMPS program (given the existing infrastructure). However, these agencies had to re-engineer their clinical approaches to change their staff s approach to better serve youth and families. Some EMPS contractors recruited staff that previously worked in adult crisis response systems. In both instances, EMPS contractors and family advocates reported that extra time and training was required to educate these staff about youth and family assessment practices, crisis intervention approaches, and the complexities and interrelationships among the elements of youth-serving systems. Some agencies indicated that these staff continue to need more supervision than their counterparts that have experience in treating youth and families to ensure their successful transition to providing crisis services to youth.

*Responsibility for Crisis Response/Resolution*

There continues to be confusion regarding who is responsible for providing crisis services. In some EMPS sites, the team is reluctant to initiate mobile services if a provider or practitioner that already serves the youth initiates a call to EMPS. Some EMPS teams feel strongly that the existing provider should be the first line of crisis response. Some providers and other stakeholders expressed frustration with this approach, stating that providers and particularly independent practitioners can not be mobile, available on a 24/7 basis or can not assume responsibility for all crises experienced by youth and families in their care.

There is also some confusion as to who is eligible for receiving EMPS services. Some teams report that consumers in Care Coordination are not qualified to receive EMPS mobile services. The service delivery link between EMPS and Care Coordination in most regions has not yet been clearly articulated.

Another example of confusion about eligibility was related to consumers in other DCF services. Several teams reported receiving requests for mobile response from DCF shelters and foster homes. Community Collaborative representatives expressed concerns about the degree to which the EMPS system should be a safety valve for other DCF funded providers or service models. This confusion continues to result in some variability in how crisis responses for EMPS services are prioritized and initiated. This may result in youth more likely to be referred to emergency departments if the provider

or the EMPS staff are not clear regarding the roles, responsibilities and population eligible for EMPS services.

*Relationships with Emergency Departments in Hospitals*
A key element of the EMPS strategy is to: work collaboratively with hospital emergency departments (EDs), assist in crisis response and stabilization and divert youth to appropriate alternatives to inpatient hospitalization. As noted earlier in this report, many of the EMPS programs have developed memoranda of understanding with local hospital EDs to implement these objectives. Nonetheless, many of the EMPS respondents reported that there are some barriers to effective working relationships between EMPS programs and EDs. Once a youth has been admitted to the ED, it becomes more difficult to divert or prevent inpatient admission, even if no child/adolescent inpatient beds are available for immediate admission.

One barrier identified through the site reviews was the federal examination and treatment for emergency medical conditions regulations (EMTALA regulations, 42 CFR 1395dd). These regulations require hospitals or hospital emergency departments to provide for an appropriate medical screening examination to determine if an emergency medical condition exists. If the emergency department determines that the individual has an emergency medical condition, the hospital must provide further medical examination and treatment or transfer the individual to another medical facility only if the patient agrees with such transfer. EDs have significant concerns regarding their liability if they do not perform the initial medical screening as well as concerns regarding any transfers to EMPS since they may not be considered a medical facility.

Another barrier to EMPS working with EDs was reported to be hospital credentialing and privileging practices. Physicians privileged to a given hospital ED may emphasize that they are the only professional that can make decisions about clinical care of patients in the ED. Interviews with ED staff indicated that EMPS staff were not yet seen as a resource to reduce admissions into EDs or to divert youth from inpatient hospitalization. EMPS staff without hospital credentialing or privileging were sometimes perceived to have no legitimate role in clinical decision-making or presentation of alternatives to hospitalization.

These barriers have limited the EMPS contractors ability to divert children from EDs and inpatient psychiatric units. Youth continue to wait for days in an emergency department for an available inpatient bed.

*Service Access*
Perhaps the greatest barrier to EMPS implementation and proper functioning identified in the site reviews was the lack of access to community services for youth and their families. This lack of access to community services was reported to contribute to the long lengths of time necessary to resolve many crisis situations, and may also be related to the inability to prevent or divert some inpatient admissions.

EMPS program respondents perceived three different issues related to service access. The first issue was lack of timely access to child psychiatry for diagnostic assessment and medication evaluation. The EMPS teams reported that the psychiatry time made available through the EMPS program was very helpful, but that the amount of time was insufficient. Access to private practice psychiatrists was also reported to be difficult. Many psychiatrists practices are full and some private psychiatrists are reluctant to see more difficult youth or do not want to take Medicaid reimbursement rates.

The second issue was lack of access to new and non-traditional community services, including in-home supports, therapeutic mentoring, etc. Some of these services were being developed (e.g., psychiatric in-home services), but were not yet at full capacity or already had waiting lists.

The third issue was access to the more traditional child guidance services, including outpatient counseling, partial hospital and extended day treatment programs. Even EMPS programs that were embedded in child guidance agencies reported long delays in accessing these types of services. Respondents reported very few situations in which child guidance clinics or other community providers made special arrangements to accommodate referrals from EMPS programs.

The limited availability of after care services for EMPS recipients is adversely affecting future EMPS capacity. Some teams are beginning to experience bottlenecks in providing services. Virtually all of the EMPS programs reported they had substantial numbers of youth and families for whom the crisis could not be resolved or referral to follow-along services was not completed within six to eight weeks. Team members reported carrying caseloads of five to fifteen consumers/families at any given time, with as many as one-half going beyond eight weeks of service.[3]

*Hours of Operation*

The EMPS program has limited mobile response capacity. Unlike many youth crisis programs in other states, the EMPS program was not funded sufficiently to allow face to face assessments to occur 24 hours a day, 7 days a week. Although there is availability of phone assessments when mobile capacity is no longer available (overnight and extended weekend hours), interviewees indicated that many crises occurred in the late evening, overnight (especially for teens between 13 and 17) and on weekends. EDs, human service providers and other potential referral sources do not feel that a phone assessment and next day follow-up appointment is sufficient to address these off-hour crises. Therefore, the continued patterns of referrals to police and EDs continue when mobile response is not available.

**Care Coordination**

*The Care Coordination Model*

Care Coordination is intended to be a *six-month* program that includes assessment,

[3] Not all of these reported situations involved frequent encounters or ongoing mobile encounters. Many ongoing encounters were provided by individuals as opposed to teams, and frequently the case manager on some teams was the provider of ongoing service encounters.

service planning via the Child Specific Team, and service brokering. Interviews with contractors and care coordinators suggest that there is little support for the time-limited model. Two issues are relevant here. First, care coordinators do not appear to understand the model. Many cited the chronic nature of serious emotional disorders as a reason why time-limited care management is inappropriate. If there is a theoretical model underlying this time limitation, the care coordinators have not absorbed it and do not appear to have good strategies for handing off their cases after the six-month time limit. In fact, most report that many of their cases are running or will run longer than six months. Some express concern that there is no step-down model of care management that could insure that the service plans put in place by care coordinators do not fall apart after the case is closed. Second, care coordinators cite the lack of community services as a severe constraint on their ability to discharge cases within the six-month time frame. Long wait lists for services such as after school programs, outpatient therapy, medication evaluations, therapeutic mentoring and respite, and transportation mean that care coordinators must hold on to cases longer than would otherwise be necessary.

*Working with Community Collaboratives*

As defined in the Practice Standards for Systems of Care/Community Collaboratives, care coordinators are intended to work closely with Community Collaboratives to insure that services are child/family centered and respond comprehensively to the child/family s needs. In practice, there is wide variation in the degree to which care coordinators work with the collaboratives.

The role of the Community Collaboratives has changed quite dramatically over the past few years. Historically, the collaboratives reviewed individual cases, frequently without the family member being present. Concerns about confidentiality and the desire to make this process more empowering to parents caused a shift in this role. Current Practice Standards place a far greater emphasis on the system development function of collaboratives and relegate the case review function to an ad hoc committee that meets in the presence of the family. In many collaboratives, this has been a difficult transition and has resulted in confusion about the collaborative s role and some degree of dissatisfaction among collaborative members.

Despite this difficult transition, the Care Coordination/Community Collaborative partnership is thriving in a few areas. In one region, care coordinators receive most of their referrals from the collaborative and the collaborative is an active partner in securing services. One parent, speaking of the collaborative s case review function said that when it is working it s like watching a picture develop. In most, however, this linkage is less clearly defined. Some care coordinators report that they receive little help from the collaborative. They feel that members lost interest in the activity once the case review function was removed. Many care coordinators report that the collaboratives have been slow to pick up the system development function. Some also believe that the collaboratives Case Review Committees are redundant because the Child Specific Team should assume this function.

*Regional Differences in Understanding Care Coordination*
Many contractors and care coordinators believe that there is a pervasive lack of understanding of KidCare within DCF. This applies to both the individual DCF workers and the regional structure. They believe that many DCF workers have not gotten the message and do not yet subscribe to the family empowering component of KidCare. At the regional level, they cite numerous instances in which the regions have given them instructions that differ from their own understandings of the Care Coordination program or that differ from region to region. Examples include:

- Children in Care Coordination are not eligible for Voluntary Services because they will be eligible for so many services via Care Coordination.
- Children in foster care are not eligible for Care Coordination.
- Children in shelters are not eligible for Care Coordination.

*Role of the Family Advocate*
Care coordinators are unanimous in their support for the family advocates. These individuals make important contributions in supporting families and in many cases, the family advocate is seen as the expert in working with the schools. As one care coordinator noted, the care coordinators are supposed to act as mediators and the family advocate is free to push a little harder to get the schools to bring resources to the table. However, there is some lack of clarity about the family advocate s role.

There are no written policies and procedures for the advocates around such issues as confidentiality, using standardized releases of information, and the relationship between the advocate and the care coordinator on the one hand and the family on the other. The family advocate s caseload is supposed to include no more than 20 cases. When the care coordinators caseloads become full, the number of active cases for the family advocates will far exceed this number. There are currently no criteria that would assist care coordinators and family advocates in making decisions about prioritizing cases.

*Paperwork*
Care coordinators uniformly cite the burden of new paperwork. However, they also believe that the new Uniform Client Record is helpful in organizing their cases. The amount of paperwork, however, is seen as a barrier to getting services for children and their families. Many care coordinators believe that the Care Coordination policies and procedures specify that the Child Specific Team cannot meet until the assessment paperwork is completed. This means that families may have to wait six to eight weeks before the actual service plan can be developed leading to frustration and the possibility that the child s condition may become more acute. Other care coordinators do not hold this view. Clarification of this point would be helpful. Additional concerns about paperwork relate to redundancy and what is perceived as a cumbersome format. Some contractors have also complained about their inability to access their own information after it is submitted to DCF.

*Managing Contracts*
Contractors cited difficulties in managing the multiple subcontracts involved in the EMPS and Care Coordination programs. In some cases, issues have arisen around proper communication between the contractor and subcontractors. In other cases, the issues relate to the difficulties of supervising staff that are not the contractor s employees.

*Referrals to Care Coordination*
Programs vary considerably in terms of the sources of their referrals. In some areas, the majority of referrals come through DCF. In one area, most referrals come through the Community Collaborative. In other areas, the referrals come from a variety of sources including families, schools, the courts, providers, and DCF. Contrary to what one might have expected, very few referrals to Care Coordination come through EMPS. In fact, in some areas the arrow goes the other way and care coordinators are using EMPS clinicians to provide clinical services to children with acute needs who are not able to access core community services because of the long waiting lists.

# CHAPTER 4: FACTORS THAT FACILITATED IMPLEMENTATION

All interviewees were asked to identify the state and regional factors that enhanced the implementation of the Emergency Mobile Psychiatric Services and Care Coordination Programs. The respondents indicated that the following factors have positively influenced program start up: the contractor s recent history of providing either or both services, the statewide KidCare Training, the involvement and support of Community Collaboratives, the existing relationships between local providers and the Uniform Client Record. Each of these factors are discussed in more detail below.

**Prior History of Providing the Services**

Prior to the implementation of the EMPS and Care Coordination program, the Department of Children and Families did purchase these services; however, on a much more limited basis. Contractors that provided emergency services received approximately $50,000 to provide limited screening and assessments. Services were not available 24 hours a day, 7 days a week. Care Coordination services were also more limited. Prior Care Coordination contractors generally employed no more than a few care coordinators per region. There were few constraints on caseload size or the length of time a child or youth received Care Coordination.

Almost one-half of the current EMPS and Care Coordination contractors or subcontractors had previous emergency services or Care Coordination contracts. Interviewees indicated that the start-up time for these contractors was less than for new contractors, especially for Care Coordination services. These organizations already had an established program within their agency and some protocols for delivering Care Coordination services. Care Coordination services under the KidCare Initiative required that these agencies retool their existing programs rather than create new structures, policies and procedures.

**KidCare Training**

The Child Health and Development Institute of Connecticut, Inc. (CHDI) developed a comprehensive training regarding the Connecticut KidCare Initiative for DCF staff, provider agencies, Community Collaborative representatives, family advocates and other stakeholders. This training focused on the KidCare System of Care values and principles, new roles and responsibilities of the Community Collaboratives, greater focus on families as active participants in the service planning and delivery process and use of natural and community supports versus traditional mental health treatment and support services.

Family advocates and Care Coordination staff stated that the KidCare training was helpful to indoctrinate the vision and philosophy of the System of Care Principles in the development of the new Care Coordination program. These individuals indicated that the training was most useful for developing the Individual Service Plan, conducting the Child Specific Team meetings and empowering families to assume care coordination responsibilities in the long term.

**Staff Attitudes**
Universally, staff are excited about the promise of the EMPS and Care Coordination programs. Staff interviewed were often involved in the design and implementation of the program allowing staff to have significant ownership in the success of the program. This ownership manifested itself in several ways:

- A willingness to work extra hours and odd shifts to assure proper response to youth and families in both programs.
- An openness to suggestions for improving their program.
- Less turnover in these programs than in other parts of their agencies.

**Uniform Client Record**
Although Care Coordination staff voiced concerns regarding the increase in paperwork under the new Care Coordination program, many program managers considered the Uniform Client Record as a useful tool for collecting and organizing information. Staff that were responsible for reviewing records found that the UCR packet was helpful in their efforts to perform internal quality management activities. Program administrators found the UCR helpful in guiding their agency s efforts to make changes to their information systems to accommodate DCF reporting requirements.

The UCR also provided uniformity regarding the format of the assessment and service plan. Parents who were interviewed indicated that the service plan was easy to understand and allowed them to track the activities and responsible parties.

**Community Collaborative Involvement**
Under the KidCare Initiative, the roles and responsibilities of the Community Collaborative changed. Several collaborative members expressed their concerns regarding the move from individual case planning to more systemic planning and resource identification. However, collaboratives that welcomed this transition were a very useful resource to care coordinators and parents during the Child Specific Team process. Specifically, care coordinators identified that these collaborative members played a significant role in identifying and developing resources that were helpful not only to a specific child or youth but to other children.

**Existing Relationships Between Providers**
Agencies that received EMPS and Care Coordination contracts identified local provider network support as a factor that facilitated implementation. In some regions providers worked collaboratively on the procurement and implementation. These providers met prior to the submission of the EMPS or Care Coordination proposal to identify who would be the lead agency and the roles of the contractor and subcontractors. The venue for these meetings varied. Some regions used the existing collaboratives for making decisions regarding the local design of the EMPS and Care Coordination programs. In another instance, a local workgroup was formed specifically to develop systemic and individual strategies for diversions from ED and inpatient psychiatric hospitalization.

# CHAPTER 5: ISSUES REQUIRING FURTHER ANALYSIS AND DISCUSSION

As the EMPS and Care Coordination programs enter their second year, there are several issues that the Department should address to enhance the effectiveness and outcomes of these programs. These issues reflect changes that should be considered for the children s Connecticut KidCare program and programmatic changes specific to the EMPS and Care Coordination program. Several of these issues can be resolved with additional clarification of intent and policy. Other issues will require long-term strategic solutions and resources.

**System Issues**

This report identified several key barriers that were identified as a result of the implementation analysis of EMPS and Care Coordination. Some of these issues were not specific to these programs but were barriers to youth and their families who were seeking or receiving services from the publicly funded mental health system. These barriers included limited access or knowledge of intensive mental health services and supports in local communities,

*Service Availability*

As indicated in the previous section, service availability will continue to impact the effectiveness of this model. Almost every interviewee indicated frustration with the lack of available services to address the behavioral health needs of children and youth. The lack of available service will affect the integrity of the EMPS and Care Coordination models. The review team has already identified several EMPS programs that are serving children well past eight weeks when the appropriate transition treatment and supports are not available. Care Coordination will become a service and not a function. care coordinators, family advocates, and families indicated that in some instances a child was receiving Care Coordination because other treatment services are not available. Some care coordinators remarked that there are no services to coordinate; therefore, Care Coordination was really an oxymoron. A review of the services requested by care coordinators in initial assessment indicated youth and their families most often needed the following services:

- Mental Health Counseling Individual (40%)
- School Intervention (30%)
- Mentoring (27%)
- Respite (24%)
- Extended Day Treatment (23%)
- In-Home Services (21%)

*Staff Recruitment and Retention*

EMPS and Care Coordination face many workforce challenges. Issues related to recruitment of qualified staff, culturally competent staff, and staff willing to perform mobile services have been identified by most programs. As EMPS and Care Coordination are maintained and expanded, the need and competition for such staff will

only increase. DCF may want to consider two strategies to partially ameliorate these issues in the future. First, DCF could work directly with graduate schools and other potential sources of employees to: (a) advertise and perhaps quantify the growing demand for licensed staff; and (b) to stimulate graduate and other professional training programs to include skill and knowledge development related to mobile crisis response interventions for youth and their families. Second, DCF could initiate and maintain a clearinghouse of career opportunities throughout the DCF system, which could facilitate recruitment efforts and encourage entering the DCF system (both direct and contracted) as a pathway to professional development.

There is a need to focus some energy on staff development for this next year. Ongoing staff turnover will necessitate that individual agencies offer the required training (e.g., mandated reporting) on a regular basis. In addition, DCF should coordinate local staff development efforts that focus on enhancing crisis intervention and stabilization.

*Develop Better Cooperative Relationships Among Emergency Services and Inpatient Hospital Providers*

In some regions, admissions to inpatient psychiatric hospital for children and youth are increasing. One hospital emergency department reported an increase of 18% from December 2001 to December 2002. Most ED staff interviewed indicated that EMPS held some promise; however, this program is yet to be seen as a viable resource for diverting children and youth with acute psychiatric symptoms from emergency department visits or hospitalization.

These barriers may be mitigated as the memoranda of understanding are more fully developed and implemented, and as hospital emergency departments gain experience working with the EMPS programs. DCF should consider developing a template for EMPS programs to use in the next iteration of the MOUs. It may be helpful to work with the Connecticut Hospital Association in the development of this MOU. At a minimum the MOU should address:

- Target population for EMPS referrals;
- Process for triage and referring youth from ED to EMPS program during mobile and non-mobile hours;
- Clear roles regarding the final disposition regarding youth seen in the emergency department;
- Participation by EMPS staff in the assessment and disposition process (e.g. EMPS possibly providing recommendations regarding disposition);
- Protocols for youth who have been assessed by EMPS staff with a recommended disposition for inpatient behavioral health care; and
- Role and responsibility of EMPS staff accompanying youth and families to ED if they require emergency care

DCF may also want to consider a more permanent committee comprised of representatives from EDs, EMPS contractors, DSS and DCF to develop strategies for addressing the federal EMTALA regulations, identifying a model for EMPS involvement

in assessment and dispositions of youth in EDs, and resolving ongoing implementation issues between EDs and EMPS.

EMPS programs should also continue to seek ways to intervene in the crisis-response trajectory before a child or adolescent is transported to the emergency department. Additional marketing and community education efforts may be helpful in this regard. However, it may be necessary for DCF to work with other state agencies and local providers to assure that EMPS is the referral of choice, not just one alternative to be considered when responding to youth in crisis.

**Program Changes**

There were several issues that the Department should address over the next year that are specific to the EMPS and Care Coordination program. The programs are operating well for the first year. The following year should focus on fine tuning the program models and protocols as well as clarifying several key policy issues such as program eligibility, service documentation, and hours of operation.

*Clarifying Eligibility for Services*

The lack of clarity regarding eligibility for the EMPS and Care Coordination programs could be corrected through issuance by DCF of policy guidance. Such guidance should be circulated or publicized to all other providers and DCF programs, to assure that knowledge and expectations related to priority access to EMPS mobile services are clear to all parties.

Most interviewees noted the high proportion of youth with private insurance among those referred for mobile crisis response. In several sites, this proportion was reported to exceed 50% of total referrals. Some concern was expressed that EMPS and Care Coordination was providing a convenient safety valve for private insurers and managed care companies unwilling to pay for such services. However, it had also been noted that Connecticut has a relatively high proportion of privately insured youth compared to other states, and that youth in public programs are more likely to be already receiving services, and, thus, be less likely to need crisis response services.

This issue bears further analysis. It may be that the more pressing issue is to market EMPS as a cost effective intervention for private insurers, and to find ways to structure the EMPS service so it becomes more readily reimbursable by private insurers.

*Service Documentation*

A major concern of the review team was the lack of documentation in client records. Despite DCF s efforts with the UCR, many Care Coordination agencies could benefit from additional training regarding the UCR. In addition, it may be helpful to consider how the Service Effectiveness Coordinator could be helpful in developing an internal review process to ensure documentation is complete and accurate.

EMPS providers need guidance regarding their documentation. Lack of clear documentation raises significant clinical liability issues for these programs. The lack of a

clear crisis plan hampers EMPS, caregivers and other provider s efforts to effectively respond to crisis or may result in implementing crisis techniques that may be inappropriate or ineffective. There is confusion regarding the expectation of DCF and other payers regarding assessment and treatment plan information for EMPS clients. The requirements regarding safety and crisis plans is unclear and warrants further delineation by DCF. At a minimum, it is expected that the crisis plans should:

- Be written in language understandable to the youth and the caregiver;
- Provide evidence of review and discussion of the plan with the caregiver;
- Delineate crisis triggers for the youth and family; and
- Provide step by step action for the youth/caregiver in the event of a crisis inclusive of who to contact and any other action to be taken.

DCF is in the process of developing Practice Standards for EMPS. These Practice Standards should address documentation.

Documentation is also important for revenue generation. Some EMPS providers can bill third-party payers for some interventions. These payers require the provider to maintain adequate assessment and progress notes as a requirement for payment. In some instances, the third-party payer may review this documentation to determine if the provider keeps or returns the payment. There is a need to develop a standardized record format for EMPS.

*Staff Safety*

Employee safety is always a primary concern of staff who respond to volatile situations in potentially unsafe homes or neighborhoods. While most of the EMPS programs have staff safety policies and procedures, these did not consistently provide guidance on risk assessment techniques and criteria for initiating various safety protocols.

In general, EMPS team respondents reported that if there was any question about the risk of going to a home or neighborhood, the family would be told to proceed to the hospital ED. In rare circumstances, the risk appeared serious enough to precipitate a call to 911. A few respondents stated that a decision about whether to respond with a team as opposed to an individual would be based on an informal risk assessment. In some programs a substantial proportion of first encounters were seen in the EMPS offices. For all of these reasons, it was reported to be somewhat rare for an EMPS team to be responding to a home or neighborhood where safety would be a significant concern.

The appropriate assessment and response to staff risk is an essential capacity of any mobile crisis response program. Being too cautious about staff risk could result in more frequent ED referrals and/or inpatient hospitalizations than necessary. However, the actual risk to staff must be minimized as a first priority. DCF may wish to work with EMPS programs to develop standard risk assessment and management protocols, and to circulate training materials based on these safety protocols for inclusion in EMPS staff orientation and training activities. These risk assessment protocols should include:

- Availability and use of cell phones and pagers;
- Making contact with the youth/caregiver prior to entering the home;
- Verifying that potential weapons are secured and out of reach of the youth/caregiver (if appropriate);
- Being clear when to call the police if situation gets dangerous; and
- Ensuring that someone within the program knows the staff whereabouts and time of proposed interventions.

*The EMPS Model*

The Connecticut EMPS model is different from traditional crisis response models used previously in Connecticut and in most other jurisdictions. Typical crisis response programs use a 24/7 on-call system with mobile response capacity used primarily for ED-based hospital pre-screening, diversion and stabilization. These traditional crisis response models do initial assessment and referrals, but do not provide any ongoing treatment and do not continue services while the consumer awaits connection to other community services.

In some systems with well-developed crisis response capacity (e.g., Wraparound Milwaukee), the crisis response is integral to the family-based service model, and can be either brief or extensive based on the individual needs of consumers and families. These more developed crisis-response models are typically characterized by financial risk for inpatient costs, and authority to manage inpatient admissions and access to other high cost services. The most mature models of crisis response also have direct access to a variety of crisis diversion resources such as 23-hour respite beds, short-term intensive residential treatment options, and therapeutic foster care.

The current EMPS model in Connecticut is different from both the traditional short-term crisis response approach and the extensive, wraparound approach used by Milwaukee. EMPS can provide up to eight weeks of crisis response treatment and family stabilization as well as initial mobile response. However, EMPS does not bear financial risk for inpatient utilization, nor does it have the authority to approve or deny hospital admission or continuing stay. In addition, EMPS is not intended to stay with a consumer or family beyond eight weeks and thus, must manage the clinical transition as well as crisis stabilization, treatment, and referral processes.

Although the EMPS programs have the stated mission of stabilizing crises and assisting youth and families to remain unified and living in the community, the programs do not have direct accountability for either ED or hospital referrals or utilization. Nor do they receive regular and consistent information about local ED and hospital utilization patterns. EMPS programs must depend on the good will of community resources to receive referrals, and also to be successful in referring consumers and families to other community resources once the crisis is resolved.

Another factor related to the current Connecticut EMPS approach is the lack of evidence-based knowledge about short-term (six- to eight-week) treatment intervention models for youth and families in crisis. It is clear to the members of current EMPS teams that such

brief interventions can work, but it is not clear how well they work and for which types of consumers and families. There is anecdotal information from the EMPS programs that appears to support identification of three groups of consumers seen in crisis: (1) individuals and families needing immediate intensive services who are referred to EDs for assessment and most likely inpatient admission; (2) consumers and families with complex issues for whom long periods of time may be necessary to arrange linkage to appropriate community services;[4] and (3) consumers and families for whom a brief crisis response is sufficient to attain stabilization and to facilitate follow-up with available community resources. These latter consumers and families may be primarily intact families with good support systems experiencing a moderate or preliminary crisis situation. For all of these groups it will be important to develop and continuously refine differential clinical practices and guidelines to assure appropriate and beneficial interventions.

Another implementation issue related to the EMPS model is the extent of variation among the EMPS programs. Some tend to go mobile for most referrals, while others use more extensive telephone triage and referral and perhaps encourage office-based as opposed to mobile visits. Some programs report using individual encounters for most interventions, while other programs report most frequently using a team approach. Some programs report having close working relationships with other community resources such as Community Collaboratives and family advocates, while others report infrequent contact with these resources. As with the above discussion, these variations do not necessarily represent either good practice or bad practice. They only represent differences that warrant further attention and study, to see whether there are any connections between varying approaches and the relative cost and effectiveness of different EMPS program models.

A final issue related to the EMPS model is managing the clinical transition from EMPS clinical treatment to some number of community resources. To be effective, EMPS staff must forge close, trusting clinical alliances with youth, and also frequently with their families. Some of these youth and families have had difficulty in engagement or poor experiences with providers in the past. Thus, the engagement and clinical alliance process may be difficult to accomplish in and of itself. Further, the difficulty of engagement may be exacerbated by the immediate clinical focus on transition to other community resources as opposed to formation of a clinical alliance. This clinical process requires different clinical skills and techniques than most typical clinical interventions. Continued attention should be paid to learning from how EMPS team members manage this clinical transition process, with the objective of sharing effective techniques and increasing youth and family success with both crisis treatment and ongoing services.

*The Care Coordination Model*

As with the EMPS program, the Care Coordination model being used in Connecticut is not one that has an extensive evidence base supporting it. This is not to say that it may not be an effective program. But it does suggest that the program warrants continued evaluation. It will be important to understand whether the model works better for some

[4] Some proportion but not all of these may qualify for referral to Care Coordination.

children and families than for others. It will also be important to determine whether effects achieved during the Care Coordination period are maintained over time. That is, do the community services packages that are implemented through the Care Coordination program survive and evolve as the child ages, experiences changes in needs and as staff in community programs turn over. Also important is the degree to which parents learn to advocate for themselves and their child as needs evolve over time. The current evaluation of the KidCare Care Coordination program is a start. However, this substudy is primarily examining the process of care coordination. It has not been designed to analyze the longer-term effects. It may be possible to build this element into successive years of the evaluation.

A second issue worth further consideration is the degree to which care coordinators themselves fully understand the model and their roles in the system of care. During interviews, care coordinators frequently noted that the six-month time limit did not make sense for children whose needs for intensive services can be expected to continue for a considerably longer time. For many of the children in Care Coordination, this is a reasonable assumption. However, the Care Coordination model that has been chosen in Connecticut is time-limited and it is important that the expectations and limitations are very clear to staff who are carrying it out. This time-limited model requires that staff understand what the objectives are, how to manage their time, how to maintain clear distinctions between clinical interventions and service package construction, and how to best equip parents and children for case closure. It is possible that more clear guidance about the steps involved in Care Coordination, reasonable expectations about the timing of the Child Specific Team meeting, and the appropriate boundaries of the care coordinator role might make staff more comfortable with the program.

**Final Considerations**

Over the next year, DCF should assess each contractor s fidelity to the EMPS and Care Coordination models. This implementation analysis identified whether each program had the appropriate plumbing to operate the service. The Department should develop a fidelity scale of critical elements that programs can use to assess their adherence to the program models. The Department should also perform a fidelity review of select programs for the purposes of providing technical assistance. This review could also identify agencies that can mentor newer or peer agencies that may need assistance to better adhere to the model.

## Attachment #1:
## Interview Protocols

# Regional Interview Guide for Implementation Analysis

Tell us about the implementation process:

(All interviewees)

1. Do you have a relationship or affiliation with the EMPS and Care Coordination agency? Describe the relationship/affiliation.
2. Have you referred individuals or made a direct referral for EMPS and Care Coordination services? What was your or their experience with the services?
3. What factors, if any, facilitated the implementation of the EMPS and Care Coordination program in your area?
4. What barriers, if any, did you experience or perceive regarding the implementation of the EMPS and Care Coordination Program in your area?
5. Has the implementation of the EMPS and Care Coordination Program changed the relationships among local child-serving agencies? If so, describe the change.
6. Were you involved in the agency's efforts to implement EMPS and Care Coordination? Describe the involvement.
7. Were you involved or aware of the agency's efforts to implement a community education and marketing initiative regarding EMPS and Care Coordination Services? What is your perception of the agency's marketing efforts?
8. Are you aware of the 800 number for EMPS and care coordination services? How were you made aware of this number? Do you think the community is aware of this service?

(Family Advocate)

9. Describe your level of involvement with implementing EMPS and Care Coordination.
10. Were you asked to participate in the care coordination selection and hiring processes?
11. Have you had any contact with children or families that initially used EMPS or Care Coordination? If yes, do these families feel they were involved in decisions regarding the service planning process?
12. Have families who are receiving EMPS or Care Coordination services requested your assistance? If so, please describe the assistance requested?

(Community Collaborative Representatives)

13. Do EMPS/Care Coordination staff participate in the local collaborative? Are EMPS team members and care coordinators participating in child specific teams? How would you describe their participation? What recommendations, if any, would you make to enhance their participation?

(DCF Regional Staff)

14. Describe your level of involvement with implementing EMPS and Care Coordination.
15. Did the EMPS and Care Coordination Contractor request support from DCF? What was the nature of the support? What additional supports do you think they may need over the next 12 months?
16. Did you review the clinical decision making protocols for EMPS and Care Coordination? What was your impression of these protocols? Did you request specific changes and were these changes made?

(EMPS/Care Coordination Contractor)

17. Are providers willing and able to accept referrals from EMPS teams and/or care coordinators for ongoing treatment? Are children, adolescents and families able to access these services in a timely manner? If not, what are the services that are most difficult to access?
18. Have you requested support from the DCF Regional Staff for this project? What types of support was requested? Was support provided? Were you satisfied with this support? If not, why?
19. What challenges did you encounter during implementation?

(Providers)

20. Have you experienced any immediate changes in gaining access to emergency services or care coordination services for children and adolescents with more intense behavioral needs?
21. Have you received a referral from the EMPS team or a Care Coordinator? Describe your experience with referrals from EMPS and/or Care Coordinator? Would you recommend any changes that would enhance the referral process?

# Interview Guide for Regional Representatives
# Families and Caregivers
# Care Coordination

Tell us about your experience with your Care Coordinator:

1. Do you have a care coordinator?
2. Are they helpful? Please describe.
3. How often do you see or talk to your care coordinator?
4. Does your care coordinator contact you at times that are convenient to you?
5. Does your child have a service plan?
6. Were you involved in the developing the service plan?
7. Were there other people that were helping you develop the service plan? Who was most helpful and why?
8. Are the services and supports that are needed at home, school and in the community available? If not, which ones are you not receiving? Do you know why you are not receiving these services? Is your care coordinator trying to get these services for you?
9. What changes have you noticed with your child as a result of receiving care coordination and other services?

# Interview Guide for Regional Representatives
# Families and Caregivers
# EMPS

Tell us about your experience with EMPS:

10. How did you find out about EMPS?
11. Did you call EMPS directly?
12. Was your telephone call answered promptly?
13. Was the person who answered your call helpful?
14. Did you have to wait for someone to return your call? If so, how long?
15. How quickly did EMPS respond?
16. Was EMPS staff helpful in resolving the crisis? How?
17. Did EMPS staff tell you what they would do next?
18. Did EMPS contact you the following day?
19. Did EMPS develop a crisis plan for your child and family? Were you part of developing the plan?
20. Did you receive a referral for follow-up services? If yes, what referrals did you receive?
21. Did you contact these agencies or individuals? If not, why?
22. Did EMPS offer to help you contact these agencies/individuals?
23. Did these agencies and individuals return your calls?

## Attachment #2
## Information Requested for Site Visit

# CARE COORDINATION CHECKLIST

**Documents Needed for Site Visit (Care Coordination)**

- Agency table of organization that includes Care Coordination program.
- Job Description for Care Coordinators
- Agency credentialing protocols or process for care coordinators
- Roster of current care coordination staff
- Resumes of current care coordination staff
- List of staff interpreters or contactors for non-English speaking families
- 5 records for each contractors and subcontractors*
- Agency or care coordination specific staff development plan
- Agency or staff training schedule for the next three months
- Agency mission and vision statement
- Agency policies and procedures regarding intake and service plan development
- Policies re: emergencies, injury or critical incident
- Quality management plan for agency and/or care coordination program
- Critical incident reporting policy
- Policy for staff safety
- Review of Incident and Special Reporting Issues
- Agency or program grievance process
- Agency instructions for submitting data
- Release of Information protocol and forms
- Policies re: assignment and selection of care coordinator
- Completed Satisfaction Surveys

**Care Coordination Interviewees**

- Care Coordinator Supervisor
- 3 Care Coordination Staff (could be done in a group)
- Four families (region wide) who are current or recent users of care coordination services

* For individuals that have signed a release of information form for the Department

# EMPS CHECKLIST

## Documents Needed for Site Visit (EMPS)

- Marketing materials for 800 number (in English and other languages if available)
- Emergency protocols or training manual for 800 number
- Staffing plan for 800 number
- Protocols for rolling triaging calls to EMPS team
- Number of calls by hour for one week in the previous month
- EMPS schedule for previous two weeks
- Signed MOU with hospitals in region
- List of staff interpreters or contactors for non-English speaking families
- 5 records for each EMPS contractors and subcontractors**
- Agency table of organization that includes EMPS program.
- Job Description for EMPS staff
- Agency credentialing protocols or process for EMPS staff
- Roster of current EMPS staff
- Resumes of current EMPS staff
- Agency mission and vision statement
- Agency policies and procedures regarding intake and service plan development
- Policies re: emergencies, injury or critical incident
- Quality management plan for agency and/or EMPS program
- Critical incident reporting policy
- Policy for staff safety
- Review of Incident and Special Reporting Issues
- Agency instructions for submitting data
- Community education and outreach plan
- Release of Information protocol and forms
- Completed Satisfaction Surveys

**EMPS Interviewees**

- EMPS Supervisor
- 2-3 EMPS Staff (could be done in a group)
- Four families (region wide) who received EMPS services

** For individuals that have signed a release of information form for the Department

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**www.chdi.org**

The Child Health and
Development Institute
of Connecticut, Inc.

270 Farmington Avenue
Suite 325
Farmington, CT 06032

860.679.1519 office
CHDI@adp.uchc.edu
www.chdi.org