# REPORT TO THE TWENTY-THIRD HAWAII STATE LEGISLATURE 2005

## PURSUANT TO SENATE CONCURRENT RESOLUTION 13 ADOPTED BY THE 2003 LEGISLATURE AND SENATE CONCURRENT RESOLUTION 45 ADOPTED BY THE 2004 LEGISLATURE – ESTABLISHING AND EXTENDING FOR ONE YEAR A STATEWIDE INTERAGENCY TASK FORCE TO DEVELOP A PLAN FOR COORDINATION AND EXPANSION OF SERVICES PROVIDED THROUGH HEALTHY START TO YOUNG CHILDREN AND THEIR FAMILIES

**DEPARTMENT OF HUMAN SERVICES**
**DEPARTMENT OF HEALTH**
**DECEMBER 2004**

# SCR 13/SCR 45 Task Force Report

## I. Introduction and Background

In 2003, the Hawai`i Legislature adopted SCR 13. The resolution called for the establishment of a statewide interagency task force ("Task Force") to develop a plan for better coordination and expansion of services provided through the Healthy Start programs to young children and their families. In January of 2004, the Task Force submitted a report to the 2004 Legislature outlining its work and its plans for the next year, specifically pursuing a set of 26 preliminary recommendations that had been developed during the first year, and developing a data tracking system to enable the review of changes in the system over time. The 2004 Hawai`i Legislature adopted SCR 45 which provided "a one year extension of the statewide interagency task force to continue to develop a plan for coordination and expansion of services provided through healthy start to young children and their families". A list of the members of the Task Force is included in Attachment A.

During 2004, the Task Force met eleven times as a full body to review and revise the preliminary recommendations. Members of the Task Force also met in small working groups to work on specific ideas for improving coordination and services to at risk families with young children. Concurrent to the Task Force carrying out its work, the Department of Human Services was involved in developing a Federally mandated Performance Improvement Plan ("PIP") for its Child Welfare Services ("CWS") program. The development of the PIP is important to the efforts of the Task Force, because it is anticipated that implementing the PIP will result in significant changes to the ways in which child welfare services are coordinated and delivered. Many of the changes outlined in the PIP are still to be implemented, and therefore the impacts of these changes are yet to be known.

## II. Purpose of the Report

This report to the 2005 Legislature is in response to SCR 45, adopted by the 2004 Hawai`i Legislature. This report summarizes the work of the Task Force over the past year, including a review of the accomplishments that have occurred over the past year; a discussion of the outstanding recommendations that the Task Force will continue to work on; a review of the data system that the Task Force is developing; and a discussion of the plans for the Task Force for 2005, including a request to continue the Task Force for one additional year.

## III. Accomplishments

The members of the Task Force want to acknowledge the remarkable progress that has been made in improving collaboration between the Department of Human Services' (DHS) Child Welfare Services Branch (CWS) and the Department of Health's (DOH), Healthy Start program ("HS"). The Task Force members, specifically those from the private sector, believe that the leadership of the DHS and the DOH, and the staff from both Departments, charged with working on the Task Force, are to be credited for the accomplishments that are cited in this report. Further, the Task Force notes that most of the changes that have occurred thus far have been done without the addition of new resources.

The complete listing of accomplishments that have occurred during 2004 is included in Attachment B to this report. These accomplishments are tied directly to recommendations that were developed by the Task Force and reflect action taken by the two Departments.

An early accomplishment relative to improving coordination and expanding services to young children and their families was the adoption of a Memorandum of Agreement ("MOA") between the DHS and the DOH. The MOA cited the Task Force goal of "improving outcomes among children age 0 to 5 in Hawai`i including reducing

maltreatment by improving the system of prevention and treatment services", as a goal shared by the two Departments. It outlined responsibilities of each Department and established mechanisms for communication and dispute resolution. It was signed by the Directors of both Departments in May, 2004.

In addition to the adoption of the MOA, there are a group of accomplishments specific to the coordination of services to young children and their families by CWS and HS. Among these accomplishments are: the agreement to expand HS eligibility to include families also active with CWS, including increasing the age eligibility for referrals from CWS up to age one; and ensuring better communication and cross-training of workers within the CWS and HS programs. Of particular note is the fact that a pilot project that includes a multidisciplinary model, "Enhanced Healthy Start", was established in West and East Hawai`i during 2004 to enable CWS cases to be referred to and to be served by HS providers. Federal funds of up to an additional $3.2 million from the Temporary Assistance to Needy Families (TANF) program have been earmarked by the DHS to expand *Enhanced Healthy Start* services statewide beginning with fiscal year 2005-2006.

Other changes made in 2004 include specific DOH policy changes within the HS program to allow for HS services to young children in foster care and new provisions for carrying out prenatal screening and assessment of families enrolling in the HS program on O`ahu. In addition, the DHS has made changes to its purchase of services contract for Comprehensive Counseling and Supportive Services to include child development services for biological and foster families with foster children, birth to age 5.

The Task Force believes that the actions included in the "list of accomplishments" in Attachment B are important steps to improving outcomes for at risk families with young children.

## IV. Further Issues To Be Addressed

While a lot has been accomplished in the past year toward improving coordination between CWS and HS, the remaining issues require more work to see if they need additional resources. Over the next year, the Task Force will continue to explore the feasibility of implementing these recommendations.

The outstanding recommendations fall into four general categories. They are:

1) Evaluation of programs and tools: The Task Force feels that it is very important to assess programs to determine their effectiveness. This includes both those programs being pilot tested and those that are in place. Specific attention should be given to what elements of the program contribute to program success and what evidence is there that demonstrates that the program is effective. Evaluation of programs can contribute to both program improvements and to policy decisions.

In addition to evaluating new and existing programs, the Task Force also believes that the assessment tools used in the programs should be validated and evaluated for use in Hawai`i. This will ensure that the results of the assessments and the predictive power of the assessment tools are sound in Hawai`i.

2) Recruitment and Retention: The Task Force has an interest in seeing increasing rates of both recruitment and retention of families in the HS program. Because of its voluntary nature, families have a choice about whether or not they will participate in HS. Of particular concern are the highest risk families. There are several recommendations developed by the Task Force that will be reviewed over the next year that may contribute to better recruitment and retention rates.

Healthy Start programs will now be receiving referrals from CWS. Since the needs of the families referred from CWS may be different from the families HS has traditionally served, specialized training to engage, retain and support these families may also be necessary.

3) Comprehensive health assessment of young foster children: The Task Force has developed two recommendations specific to ensuring that young children who are placed in foster care have access to a comprehensive health assessment to ensure that their developmental needs are accurately identified and that appropriate services are made available. Implementing these recommendations, consistent with Hawai`i Revised Statute §587-86, which calls for a comprehensive health assessment for children in out-of-home placements, will be pursued over the next year.

4) Improved access to treatment services: The Task Force also has an interest in ensuring access to treatment services for families with young children where either domestic violence or substance abuse problems exist. Treatment services may be necessary to ensure that the additional services of CWS or HS are meaningful.

## V. Indicators of Progress

In its first year of work, the Task Force adopted a principle that decisions should be driven by data. To this end, the Task Force spent the past year refining a set of indicators that were selected to provide feedback, over time, about changes in the system of services and resultant changes in the lives of families and young children. The complete set of indicators is included in Attachment C. Because of changes in the system of services to the target population, especially those changes that will result from the adoption of the Federally mandated PIP by the DHS, it will not be possible to collect historical data for a comparative baseline in all cases. It is anticipated that some definitions may change, as a result of the implementation of the PIP, and therefore, historical data will not be applicable to new data. In some cases, the data related to the indicator will be brand new. However, over time, baseline data will be collected for each indicator and comparisons will begin. Comparisons over time will then be made with the Task Force analyzing why the particular results are occurring.

The Task Force members believe that tracking changes related to the recent changes in the system adopted as a result of the Task Force is important. While the changes adopted appear that they will, over time, improve outcomes for families and their young children, we do not yet have evidence to support this belief. Therefore, the Task Force will monitor these changes. At the same time, the Task Force also believes that it will be useful to observe and analyze changes that are occurring specific to the adoption of the PIP.

Both Departments have indicated a willingness to share data with the Task Force as outlined in the indicators listed in Attachment C. There is, however, an understanding that the need to cross-reference data across the two Departments presents complexity and may require additional resources over time. Without the ability to accurately follow data across the two Departments, it will be very difficult to understand how the changes in the system are impacting on families and their young children.

The Task Force members recognize that the data system may require additional work over the next year as indicators are refined, baseline data is collected and, in the case of satisfaction data, survey instruments are developed. However, the members believe the results of this work will be extremely valuable, first to the Task Force, but more importantly, to policy makers within the Departments and within the Legislature.

## VI. Next Steps

The members of the Task Force are extremely pleased with the changes that have been adopted in the past year and look forward to seeing the results of those changes over time. At the same time, the Task Force does not believe that its work is complete. It has agreed that it should continue to meet over the next year, under the joint leadership of the DHS and the DOH, and with facilitation by someone who is not a member of the Task Force. Therefore, the Task Force requests that the Legislature extend the responsibilities of the Task Force for an additional year.

Over the next year, the Task Force anticipates that it will meet four to five times to carry out the following three general activities:

1) Continue to review the feasibility of implementing the remaining recommendations. As necessary, the Task Force will revise or modify the recommendations to ensure that they can be implemented and that the system serving at-risk families with young children continues its efforts at coordination and improved outcomes.

2) Complete the data tracking system, including ensuring there are data sources for each indicator and that baseline data is collected, either historically, or over the following year. To the extent needed, the Task Force will revise or modify any indicators for which data cannot be collected, or that are not reflecting the intended result.

3) Report on the Task Force findings annually to the Legislature.

# ATTACHMENT A

## SCR 13 Task Force Membership List

**Task Force Co-Chairs,** Lillian B. Koller, Esq., Department of Human Services and Linda Rosen, MD, MPH, Department of Health

**Department of Human Services**
Cynthia Goss
Pat Snyder
John Walters
Jeffrey Woodland

**Department of Health**
Loretta Fuddy
Sue Brown
Ruth Ota
Gladys Wong

**Judiciary**
Sandie Kato

**Alliance for Health and Human Services**
Ruthann Quitiquit

**Blueprint for Change Policy Committee**
JoAnn Farnsworth

**Blueprint for Change**
Lydia Hardie Hemmings

**Consuelo Zobel Alger Foundation**
Patti J. Lyons

**Good Beginnings Alliance**
Liz Chun

**Hawaii Children's Trust Fund**
Althea Momi Kamau

**Hawai`i Family Support Institute**
Gail Breakey

**Hawai`i State Senate**
Senator Suzanne Chun Oakland
Senator Gordon Trimble

**Healthy Start Program Representatives**
Patti Bates
Julie Falicki
Kristy Liphart

**Kapiolani Medical Center for Women and Children**
**CARE Program**
Dr. Victoria Schneider
Lance Segawa

**Kapiolani Child Protection Center**
Dr. Steven Choy

**Salvation Army**
Linda Rich

**Facilitator**
Janis Reischmann

# ATTACHMENT B

## Task Force Recommendations Implemented

| | Original Recommendation | Status |
|---|---|---|
| 1 | DHS and DOH will develop an MOA to work collaboratively on improving the system of prevention and treatment services for families with children 0 – 5. | MOA adopted May, 2004 by both Departments. |
| 2 | Healthy Start policy should be revised so that assessment occurs with families with newborns with active CWS cases. | Incorporated in Statement of General Policies and Procedures for Healthy Start and Child Welfare Service, dated 8.10.04. |
| 3 | Healthy Start workers may require additional training to effectively work with families with newborns engaged with CWS given the potential for resistance and the risk they present. | Incorporated in Statement of General Policies and Procedures for Healthy Start and Child Welfare Service, dated 8.10.04. |
| 4 | Case information (regarding families in #2 above) will be shared between Healthy Start and CWS. Healthy Start will keep the case open at least until CWS makes a decision about disposition. | Incorporated in Statement of General Policies and Procedures for Healthy Start and Child Welfare Service, dated 8.10.04. |
| 5 | Healthy Start eligibility may be extended up to one year for any infant where there has been CWS involvement. This will allow "re-entry" or admission to Healthy Start within one year of birth. | Extension of HS services up to one year of age for families with CWS involvement is included in new HS RFP with contracts effective 7.01.05. |
| 6 | CWS policy will allow referring open and active cases of infants up to age one to HS, provided HS is not the only service provider in the case (other services would be "side by side" with HS to ensure that appropriate services are being provided.) | Incorporated in Statement of General Policies and Procedures for Healthy Start and Child Welfare Service, dated 8.10.04. |
| 7 | When cases (see #6 above) are referred to HS, they will be tracked separately in the Healthy Start data base for evaluation purposes. | CWS cases are being tracked in HS CHEIRS data base, as of 10.01.04. |
| 8 | Revise Healthy Start practice so that the case is kept open through the CWS referral and investigation process. If the case is closed by CWS, Healthy Start services will continue. If the case is active and open by CWS, Healthy Start may be a service provider (either on a continuing basis, or as a returning case) as long as Healthy Start is not the only service provider. (See #6 above). | Incorporated in Statement of General Policies and Procedures for Healthy Start and Child Welfare Service, dated 8.10.04. |

| | Original Recommendation | Status |
|---|---|---|
| 9 | There will be cross training for CWS and HS and Diversion staff in the tools used for assessment in each program. | Incorporated in Statement of General Policies and Procedures for Healthy Start and Child Welfare Service, dated 8.10.04. |
| 10 | There will be joint training between CWS and Healthy Start to promote better understanding of each other's programs. | Incorporated in Statement of General Policies and Procedures for Healthy Start and Child Welfare Service, dated 8.10.04. |
| 11 | Procedures will be jointly developed by CWS and HS to clarify how these referrals are handled and communicated between programs. | Incorporated in Statement of General Policies and Procedures for Healthy Start and Child Welfare Service, dated 8.10.04. |
| 12 | Written agreement should be developed between CWS and HS to clarify how referrals are handled and communicated between the programs and providers. | Incorporated in Statement of General Policies and Procedures for Healthy Start and Child Welfare Service, dated 8.10.04. |
| 13 | Revise HS eligibility so that services may be available to foster families if appropriate and desired. The eligibility for HS will be based on the desire for family support by the foster parents or assessment of the worker, rather than the Family Stress Checklist assessment (FSC) score.<br><br>If reunification is a goal, then HS could also work with the biological family if the family is in the same geographic community, or it is otherwise practical to do so. | Piloted in Enhanced HS.<br><br>If return to the biological family is within two weeks - Incorporated in Statement of General Policies and Procedures for Healthy Start and Child Welfare Service, dated 8.10.04. |
| 14 | In situations where a family active with Healthy Start has a child temporarily removed, Healthy Start may be allowed to continue to work with the biological family. This would occur when the Healthy Start provider feels it is safe and appropriate, in anticipation of reunification. | Currently in Healthy Start program policies. |
| 15 | DHS should include child development services for biological and foster families in all of its services for foster children, 0 to 5. | DHS/SSD Purchase of Service Directory, 1.04, indicates some focus in child development in the Comprehensive Services contracts. DHS has agreed to look at strengthening that component in future contracts. |

| | Original Recommendation | Status |
|---|---|---|
| 16 | Specifically for very high risk families and those with drug exposed infants, reintroduce the "Mother Infant Support Team (MIST) Program" or a similar program that includes the following features:<br>✍ Multidisciplinary, including substance abuse expertise<br>✍ Contracted by DHS<br>✍ Home visitor and child development foci (more intensive services than HS)<br>✍ Workers receive some training with HS workers<br>✍ Targeted to geographically at-risk communities<br>✍ Caseloads of 12 – 15 families | Started as a pilot, "Enhanced Healthy Start" in Kona, 9.1.04 and in Hilo, 10.01.04 with contracts with DHS running through 6.30.05.<br><br>Estimates for FY 06 range from a high of 323 children aged 0 -1 based on the number of active children with CWS as of 6.01.04 to a low of 173 factoring in acceptance and attrition rates from Healthy Start voluntary services.<br><br>DHS has earmarked up to $3.2 million in TANF Federal funds to serve CWS families through Enhanced Healthy Start services statewide. |
| 17 | Revise Healthy Start policy on Oahu so that one person may be trained within programs delivering home visitor services to conduct screening and assessment for Healthy Start when there is a self or professional prenatal referral (not a hospital screening and assessment). At birth there will be a follow-up assessment by HS Early Identification (EID).<br><br>There will need to be appropriate training to ensure the individual in the home visitor program to ensure there is inter-rater reliability with EID. | To be incorporated in the July 1, 2005 contracts with Healthy Start providers. |
| 18 | CWS policy should be to make direct referrals of prenatal cases to Healthy Start. | Incorporated in Statement of General Policies and Procedures for Healthy Start and Child Welfare Service, dated 8.10.04. |

# ATTACHMENT C

## Task Force Indicators

**Population indicators for young children (0 – 5) and their families**

| # | Indicator | Data Source | Discussion |
|---|---|---|---|
| **1** | Percentage (and number) of reports, accepted for investigation, of child abuse and neglect among children, 0-5, as measured by NCANS. | **CWS to provide data for FY 02, 03, 04** | Data to be disaggregated by reports while child is in out-of-home placement and reports of suspected in home abuse.<br><br>There will not be relevant baseline data (for indicators #1 & #2) in FY 05, but believe the historical data will be useful anyway. |
| **2** | Percentage (and number) of confirmed abuse and neglect cases for children, 0-5. | **CWS to provide data for FY 02, 03 and 04** | Data to be disaggregated by type of abuse and by age (in 1 year increments).<br><br>In future years CWS intends to include data on cases that are diverted to Diversion/Family Strengthening services. |
| **3** | Percentage and number of confirmed child abuse and neglect cases for children, 0 – 5, requiring medical treatment. | **CWS to provide data for FY 02, 03, 04** | |
| **4** | Percentage and number of confirmed child abuse and neglect cases for children, 0-5, requiring hospitalization. | **CWS to provide data for FY 02, 03, 04** | |

**Target population indicators specific to SCR 13**

| # | Indicator | Data Source | Discussion |
|---|---|---|---|
| **5** | Percentage (and number) of parents of newborns screened at birth of child. | **Healthy Start to provide data for FY 02, 03, 04** | |
| **6** | Percentage (and number) of parents, screened positive, who are assessed within three months of referral. | **Healthy Start to provide data for FY 02, 03, 04** | |
| **7** | Percentage (and number) of confirmed reports of abuse or neglect among families active with Healthy Start. | **Annual Healthy Start data matched with CWS data – FY 02, 03, 04** | Disaggregate data according to Family Stress Checklist scores, in increments of 10; disaggregate data by type of abuse. |
| **8** | Percentage (and number) of confirmed reports of abuse or neglect among families served within the past one year by Healthy Start. | **Annual Healthy Start data matched with CWS data – FY 02, 03, 04** | Disaggregate data according to Family Stress Checklist scores, in increments of 10; disaggregate data by type of abuse. |
| **9** | Percentage (and number) of confirmed reports of abuse or neglect among families while being served by CWS Diversion/Family Strengthening providers. | **Annual Diversion/Family Strengthening data matched with CWS data – begin FY 05** | Disaggregate data by type of abuse; and age of child. |
| **10** | Percentage (and number) of Healthy Start families who show a decrease in family risk at discharge. | **Healthy Start data base** | Healthy Start will identify an appropriate measure for this indicator. |

**System indicators specific to SCR 13**

| # | Indicators | Data Source | Discussion |
|---|---|---|---|
| **11** | Engagement rates among positive screened families that enroll in Healthy Start. | **Healthy Start data system – baseline 02, 03 & 04** | Disaggregate data by scores, grouped in increments of 10, on the Family Stress Checklist. |
| **12** | Retention rates among families in the Healthy Start program who remain active for at least one year. | **Healthy Start data system – baseline 02, 03 & 04** | Disaggregate data by scores, grouped in increments of 10, on the Family Stress Checklist. |
| **13** | Percentage (and number) of families with young children (0-5) that are being served jointly by both DOH[1] and DHS[2]. | **Healthy Start data system** | New indicator – assume no baseline. |
| **14** | Increase in the percentage (and number) of young children (0 – 5) confirmed by CWS who receive comprehensive health evaluation.[3] | **CWS** | Assume there will be no baseline. |
| **15** | Percentage (and number) of Healthy Start families, assessed by Healthy Start with domestic violence, substance abuse, or mental health problems, who are engaged with appropriate services[4] at 6 month and 12 month intervals. | **Healthy Start data base** | New indicator – no baseline |

[1] DOH refers to both Early Intervention Services and Healthy Start Services
[2] DHS refers to Child Welfare Services and all of Diversion/Family Strengthening contracted providers
[3] Comprehensive health evaluation is an evaluation in all domains by professionals with expertise in those domains. This would include at a minimum a thorough evaluation to include gathering of medical records and an evaluation that focuses on medical health, psychological/social evaluation (over age 3), and assessment of development attainment (under age 3).
[4] Appropriate services means that the services are appropriate for the specific problem. Appropriateness is determined by Healthy Start.

| # | Indicators | Data Source | Discussion |
|---|---|---|---|
| **16** | Percentage (and number) of cases referred by DOH to CWS, in which DOH receives an assessment disposition within 60 days. | **Data will need to be matched between CWS and Healthy Start data bases** | |
| **17** | Number of cases referred to DOH by CWS. | **Healthy Start data base** | New indicator – no baseline. |
| **18** | Service satisfaction among families with children, 0 – 5, served by both DOH and DHS. | **Need to be determined** | Survey questions to be developed by a small working group. Consider the current family satisfaction survey used in the Healthy Start program. |
| **19** | Satisfaction of workers working with families jointly by DOH and DHS. | **Need to be determined** | Survey questions to be developed by a small working group. |