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| Committee: Child Well-Being/Outcomes Committee | |
| Chairperson: Larry Small and Margaret Vimont | Meeting date/location: August 20, 2015 JRTC – All participants on phone |
| Members Present: Margaret Vimont, Jennifer Prior, Steve Budde, Jennifer O’Brien, Marge Berglind, Beth Horwitz, Larry Small, Michael C. Jones | |
| Members Absent: Kristine Herman, Theresa Matthews, Toleda Hart, Dennis Wiley, John Schnier, Neil Jordan, Marc Smith, Jen Axelrod | |
| Summary of Discussion Items: Attachments: Well-being matrix and CANS for grid Committee continued discussion of proposed measures of youth well-being as referenced on the draft “Well-Being Outcomes for Youth Matrix” (attached). Group, specifically Steve B., recapped previous conversation with Dr. Jaudes regarding potential health indicators for work. Margaret noted most (if not all) of these factors will appear on the section of the chart known as “Elements that will affect well-being measure.” Jen O. suggested the grid would be more useful if we included full CANS items and descriptions, but then the group seemed to agree that we should include the CANS domain with the item name. Jen P. will update matrix to include comprehensive CANS information. Jen O. noted the Ansell-Casey assessment has been updated, now called the Casey assessment. Suggested we include Holly Bitner in our next discussion. Casey covers social emotional, cognitive and possibly physical. We need to verify how the CASEY assessment is used within the Department. Jen O. will reach out to Holly to invite to next meeting. Beth H. discussed CASEY life skills. Stated social emotional well-being items are present but won’t stand up to rigorous analysis. Noted tool is good for highlighting more individual factors rather than population trends. Chris Downs, author, referenced as an expert for practice tool. Group noted there is not good research as opposed to the CANS. Margaret noted we would want to find more of a systems tool/measurement rather than an individual level. Steve B. referenced a study out of UC Berkley – Summary of Well-Being and Ansell-Casey. Steve B. will send this study out to group. Group focused next on the Analysis or Factors affecting implementation. Margaret V. referenced communication between Department (SACWIS) and ISBE data. Also discussed status of CANS use and implementation within the Department. Discussed NU CANS and reports – e.g., reports to send to supervisor and worker. Meaningful use reports, compliance reports, 3.0 release and recertification. Jen P. asked how do we understand test scores related to education recommendations. Need guidelines for caseworker. Consult Tiffany Gholson with OETS. Group noted we need general guidelines that give the workers guidance on what to do with well-being | |

information. Practice guidelines.

Follow-up questions and actions:

1. Health information - Group discussed need to understand what currently exists regarding health information. Larry to invite Flynn from Health Policy. Also, print out and show health passport. Need to know what information is captured in the report. Also, questions related to reliability of information – e.g., how often updated and what is fed directly versus entered by worker/staff
2. School attendance – ISBE
3. 906 – less concerns about accuracy
4. Psych hospital database – list BMN and impact on well-being measures
5. Tiffany for understanding of ISBE data
6. Group to review the BH report in preparation for our next meeting. Margaret to send out.
7. Also, we need to read for next time NSCAW/ISCAW report
8. Steve B. to look at selected studies and/or evaluations.

Minutes from 7/25 meeting: CANS discussion: major obstacle at this juncture is the lack of perceived usefulness of the CANS as it is not used in discussions about youth in any wide spread context that the committee is aware of. Education is needed on not only the how to fill it out, but on the WHY to fill it out—use in supervision and in evaluating how kids are progressing will help with this moving forward. There is no ongoing training or consequence for failing to complete in many parts of the system. These are all things to keep in minds as we think about the CANS as the anchor for Wellness. There are some pockets where the data is used and where feedback is given then it is not completed or where it is completed but not accurately. These kinds of feedback loops will be critical if we move forward with this Wellness measurement plan.

| Required Action | Person Responsible | Due Date |
|--|--|-----------------|
| Contact Holly Bitner and Chris Downs for input on Casey for wellness. Also invite Tiffany Gholson for education information and Hendiz Flynn from Health Policy. | Jennifer O'brian and Beth Horwitz. Larry | September 10 |

Adjourn Time: 4:30

Next Meeting Date/Location: Thursday, September 10, 2-3:30 at Thompson Center room 215

Date Minutes Submitted: September 8, 2015, by Larry Small, DCFS

Draft of Well Being Outcomes for DCFS Youth Matrix

Updated based discussion from July 23, 2015 meeting

Measures chosen based on applicability to domain and availability of data for all DCFS involved youth, regardless of geographical location or placement. Multiple data sources used when possible.

| Domain--> | Cognitive Functioning (Education) | Physical Health | Emotional/Behavioral Functioning | Social Functioning |
|---|--|--|--|--|
| Infancy and Early Childhood (0-5) | <ul style="list-style-type: none"> • CANS: Developmental Needs, Young Child Development Needs • <i>Informed by Ages and Stages (ADQ and ASQSE)</i> | <ul style="list-style-type: none"> • CANS: Medical/Physical Health, Young Child Physical Health • Growth/Development • Combination chronic health dx and acute HHF visits | <ul style="list-style-type: none"> • CANS: Emotional strengths, traumatic stress symptoms, emotional/behavioral needs, select risk behaviors • <i>Informed by ITSC, DECA, ASQSE for under 5 group</i> • 906 for Psych Hosp. | <ul style="list-style-type: none"> • CANS: Social Functioning Strengths, Social Functioning Behaviors, and Young Child Social Behaviors • <i>Informed by Ages and Stages (ADQ and ASQSE)</i> |
| Middle Childhood (6-12) | <ul style="list-style-type: none"> • CANS: Developmental Needs and School Achievement • GPA • Standardized testing scores in reading and math | <ul style="list-style-type: none"> • CANS: Medical/Physical Health • Combination chronic health dx and acute HHF visits | <ul style="list-style-type: none"> • CANS: Traumatic Stress Symptoms, Emotional/Behavioral Strengths, Emotional/Behavioral Needs, select Risk Behaviors • School attendance • 906 form for detention • 906 and Psych Hospital Database (PHT): psychiatric hospitalization/readmission • Child Intake and Recovery Unit (CIRU) and 906: Running away | <ul style="list-style-type: none"> • CANS: Social Functioning Strengths and Social Functioning Behaviors |
| Adolescence 13-18 | | | | <p>Added for Adolescence:</p> <ul style="list-style-type: none"> • Ansell Casey • CANS: Intimate Relationships |
| Measurable factors that can affect each wellbeing domain | <p><i>Quality of Educational Context:</i> CANS: Educational Setting</p> <p><i>Outcomes in other domains</i></p> | <p><i>Health Service Quality Indicators</i> (e.g., immunizations, timely well child visits, regular dental appointments, etc..)</p> <p><i>Outcomes in other domains</i></p> | <p><i>Continuity/Quality of Care:</i> Family and Living Situation (CANS), Placement disruptions (906); staying in psychiatric hospital Beyond Medical Necessity (PHT)</p> <p><i>Family Involvement/Support:</i> Substitute Caregiver Strengths and Needs, Biological Parent Strengths and Needs (CANS)</p> <p><i>Outcomes in other domains</i></p> | |

Analysis of Factors Affecting Implementation of Proposed Instruments/Measures

| Instrument or Measure | CURRENT STATE | BARRIERS | RECOMMENDATIONS |
|---|---|--|---|
| CANS | <p>A plus that it is already expected on every child</p> <p>Questions of reliability/ validity given an uneven understanding of meaning of each item by rater.</p> <p>Uneven timeliness of submission</p> <p>Uneven perspective given the range of roles of rater (caseworker vs. clinician)</p> <p>Gaps of information held by rater</p> | <p>Overload of system</p> <p>Need for a team approach to completion for full view</p> <p>Desire/ investment of raters given the incentives present for other measures and the seeming lack of use of CANS data</p> <p>Logistical problems in having a feedback loop so that data can be used by person affecting youth</p> | <p>Based on the success of the system that is used by IPS (SOC), Integrated Assessment and Pregnant and Parenting, expand centralized system to maintain timeliness and quality.</p> <p>Re-energize educational efforts to boost meaningfulness with staff and supervisors to use in the work. Provide implementation support on site with coaching/ consultation.</p> <p>Use well-being measure to assess individual youth’s progress and for assessing the system overall.</p> <p>Use of wellness measure to assess professionals or agency success has substantial risk of positively skewing ratings. Do periodic checks of reliability and validity of ratings.</p> <p>Integrate team approach to completion as common practice</p> <p>Remove less critical data reporting to lessen reporting burden</p> <p>Implement CANS 3/1 to reduce reporting burden</p> |
| CASEY | <i>In use at different ages.</i> | <p>Could be problematic to use given episodic administration of the tool and its usefulness as big pools of data are rolled up to understand larger trends.</p> | |
| GPA & Math/ Reading Scores, School Attendance | | <p>ISBE and DCFS data communicating.</p> <p>And understanding what the scores mean</p> | <p>Tiffany may be a resource to help translate scores. Need to resolve the inter-system communication issues.</p> |
| Chronic health dx and HHF visits | <i>Supposed to be entered in system as it occurred.</i> | | <p>Committee will investigate more on this status for reliability and completeness.</p> |
| 906, Psych Hosp Report, Run unit data | <i>This set of data sources seems more complete and reliable.</i> | | |

Appendix 1: CANS Well-Being Items

| Age | Cognitive Functioning (Education) | Physical Health | Emotional/Behavioral Functioning | Social Functioning |
|--|---|--|---|--|
| <i>Infancy and early childhood (0-5)</i> | <u>Developmental Needs</u> 34: Developmental/Intellectual <u>Young Child Developmental Needs</u> 72: Motor 73: Sensory 74: Communication | <u>Medical/Physical Health</u> 37: Medical 38: Physical <u>Young Child Physical Health</u> 75: Failure to Thrive 76: Feeding/Elimination 77: Birth Weight 79: Substance Exposure (at level 3) | <u>Traumatic Stress Symptoms</u> 14: Adj. to Trauma, 15: Traumatic Grief/Separation, 16: Re-experiencing, 17: Avoidance, 18: Numbing, 19: Dissociation <u>Emotional/Behavioral Strengths</u> 24: Coping and Savoring Skills, 25: Optimism, 30: Resilience <u>Emotional/Behavioral Needs</u> 48: Psychosis, 49: Attention Deficit/Impulse Control, 50: Depression, 51: Anxiety, 52: Oppositional Behavior, 53: Conduct, 54: Substance Abuse, 55: Attachment Difficulties, 56: Eating Disturbances, 57: Affect Dysregulation, 58: Behavioral Regressions, 59: Somatization, 60: Anger Control <u>Select Risk Behaviors</u> 61: Suicide Risk, 62: Self Mutilation, 63: Other Self Harm, 64: Danger to Others, 65: Sexual Aggression, 66: Runaway, 67: Delinquency, 68: Judgment, 69: Fire Setting, 71: Sexually Reactive Behaviors | <u>Social Functioning Strengths</u> 21: Interpersonal 29: Relationship Permanence 31: Family <u>Social Functioning Behaviors</u> 33: Social Functioning 41: School Behavior 70: Social Behavior <u>Young Child Social Behaviors</u> 83: Curiosity 84: Playfulness 85: Temperament |
| <i>Middle childhood (6-12)</i> | <u>Developmental Needs</u> 42: School Achievement | <u>Medical/Physical Health</u> | <u>Traumatic Stress Symptoms</u> <u>Emotional/Behavioral Strengths</u> <u>Emotional/Behavioral Needs</u> | <u>Social Functioning Strengths</u> <u>Social Functioning Behaviors</u> |
| <i>Adolescence (13-18)</i> | | | <u>Select Risk Behaviors</u> | <i>Added for Adolescence:</i> 90: Intimate Relationships |
| <i>Elements that can effect well being</i> | 22: Educational Setting | | 20: Family 32: Living Situation <u>Substitute Caregivers Strengths and Needs</u> 129: Collaboration with Other Parents/Caregivers and 131: Inclusion of the Child in the Foster Family <u>Biological Parent Strengths and Needs</u> 132: Parent Participation in Visitation, 135: Parent Involvement/Parent Participation, and 136: Commitment to Reunification | |