Custody Relinquishment to Obtain Children's Behavioral Health Services: Current Findings and Strategies to Address the Practice

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Substance Abuse and Mental Health Services Administration

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Custody Relinquishment for Behavioral Health Services

- "Tragic" – Bazelon Center for Mental Health Law
- "Heart wrenching" – National Alliance on Mental Illness (NAMI)
- "Inhumane" – Mental Health America
- "An act of desperation" – Family Organizations

"The idea of being forced to decide between the custody of a child and accessing critically needed services for a child with severe mental illness is unspeakable, but a stark reality for too many families. As a result, many families are forced to do the unthinkable – relinquish custody of their child to the state to access services to treat the child's mental illness. (NAMI Ohio, 2005)

Definition

- Situations in which parents transfer legal and physical custody to the state in order to access services they would otherwise be ineligible for or unable to obtain
- No maltreatment (abuse or neglect) involved – parents agree to "trade custody for care," most often residential treatment
- Majority of cases child welfare assumes custody, may be juvenile justice if behavior is aggressive or "delinquent" and courts may order services
- Neither child welfare nor juvenile justice systems are designed to serve children solely because of behavioral health treatment needs

Definition (cont.)

- Some families so desperate and see no viable options that they refuse to allow children to come home from psychiatric hospitals, hoping state will take custody and their child will receive needed treatment ("psychiatric lockouts")
- Even knowing they may be treated as abusive or neglectful
- Some children are becoming "stuck" in hospital emergency rooms for extensive periods of time awaiting placement when families do not feel they can safely take them home
- Both create risk for custody relinquishment

Custody Relinquishment Revisited

- Previous analyses (e.g., Bazelon Center for Mental Health Law in 2000 and U.S. Government Accountability Office in 2003), but little current information about custody relinquishment for behavioral health services nationwide
- SAMHSA project to revisit problem and provide up-to-date information across states, progress, strategies to address the practice, inform efforts to eliminate it
- Conducted by the TA Network for Children's Behavioral Health led by University of Maryland, School of Social Work
- Companion analysis of custody relinquishment in tribes conducted by the National Indian Child Welfare Association (NICWA)
- Report in process

Methodology

- Review of literature and state-specific documents
- Informational scan to collect current information across states on the extent, reasons, how states are trying to address
  - Sent to state child welfare directors, state behavioral health directors, and family-run organizations (FROs)
  - Reponses obtained from behavioral health and/or child welfare agencies in all 50 states, 3 territories, and 18 FROs
- Informal discussions with leaders in the behavioral health and child welfare systems in selected states reporting different frequency of relinquishment, and leaders of FROs to obtain more in-depth descriptions of effective strategies and lessons learned
- Tribal scan
  - Discussions with tribal child welfare and children's mental health agencies in South Dakota and Oregon

Previous Analyses

- Portland State University 1989 – Found 25% of approximately 1,000 families received suggestions that they give up custody to obtain care
- NAMI 1999 – Found 23% of families were told they had to relinquish custody to access services
- Commonwealth Institutes for Child and Family Studies 1991 – Found at least one agency in 62% states used custody relinquishment as a method to access and finance mental health services (Cohen, et al)
- Bazelon Center 2000 – Found practice to be common in at least half of states, even those with statutes and other policies to prevent this
- U.S. General Accounting Office (GAO) 2003 – Found practice widespread, at least 12,700 instances in FY 2001 (understated because surveyed agencies in only 19 states and 30 counties), no data collected by states
- George Washington University 2005 – Found direct connection between lack of access to behavioral health treatment and entry into juvenile justice (Koppelman)

State- Specific Analyses

- Maryland 2002 – Maryland Coalition of Families for Children's Mental Health found 27% families surveyed were advised to relinquish and/or refuse to bring children home from hospitals by social services staff, therapists, hospital staff, advocates, friends, relatives
- Virginia 2005 – Legislature found it occurred primarily to obtain residential or longer-term services that couldn't be financed by insurance or other vehicles
- Utah 2007 – Disability Law Center found families could not pay significant costs and relinquishment was seen as only way to qualify child for Medicaid and access array of services in Medicaid benefit
- Texas 2014 – Legislature found cost was primary reason and parents who relinquished were placed on the state's child abuse registry with implications for their future employment (Faulkner, et al)

Consequences

Families

- Feel they have failed as parents, abandoned their children
- Lose authority to make or participate in decisions about child's life (medical and behavioral health treatment, education, etc.)
- Must go through child welfare investigation and court proceedings that are intimidating and stigmatizing
- Subject to determination of abuse or neglect, refusal to accept parental responsibility, abandonment
- Placement on child abuse registries

Children

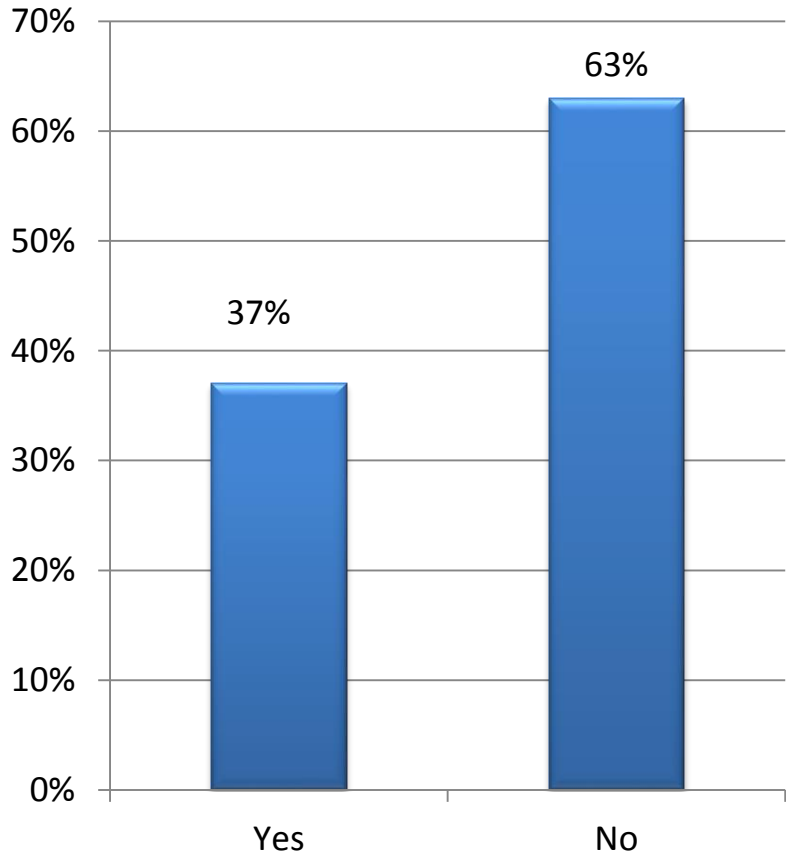
- Trauma, feel abandoned, unwanted, displaced, betrayed (especially adopted children)
- Lose contact with families, family bonds weakened
- May be arrested and placed in juvenile correctional facilities, feel punished for behavioral health needs
- May have multiple placements in residential treatment, group homes, etc.

Service Systems

- Expense for treatment, supervision, legal proceedings, placement, room and board
- Questionable outcomes from costly residential treatment

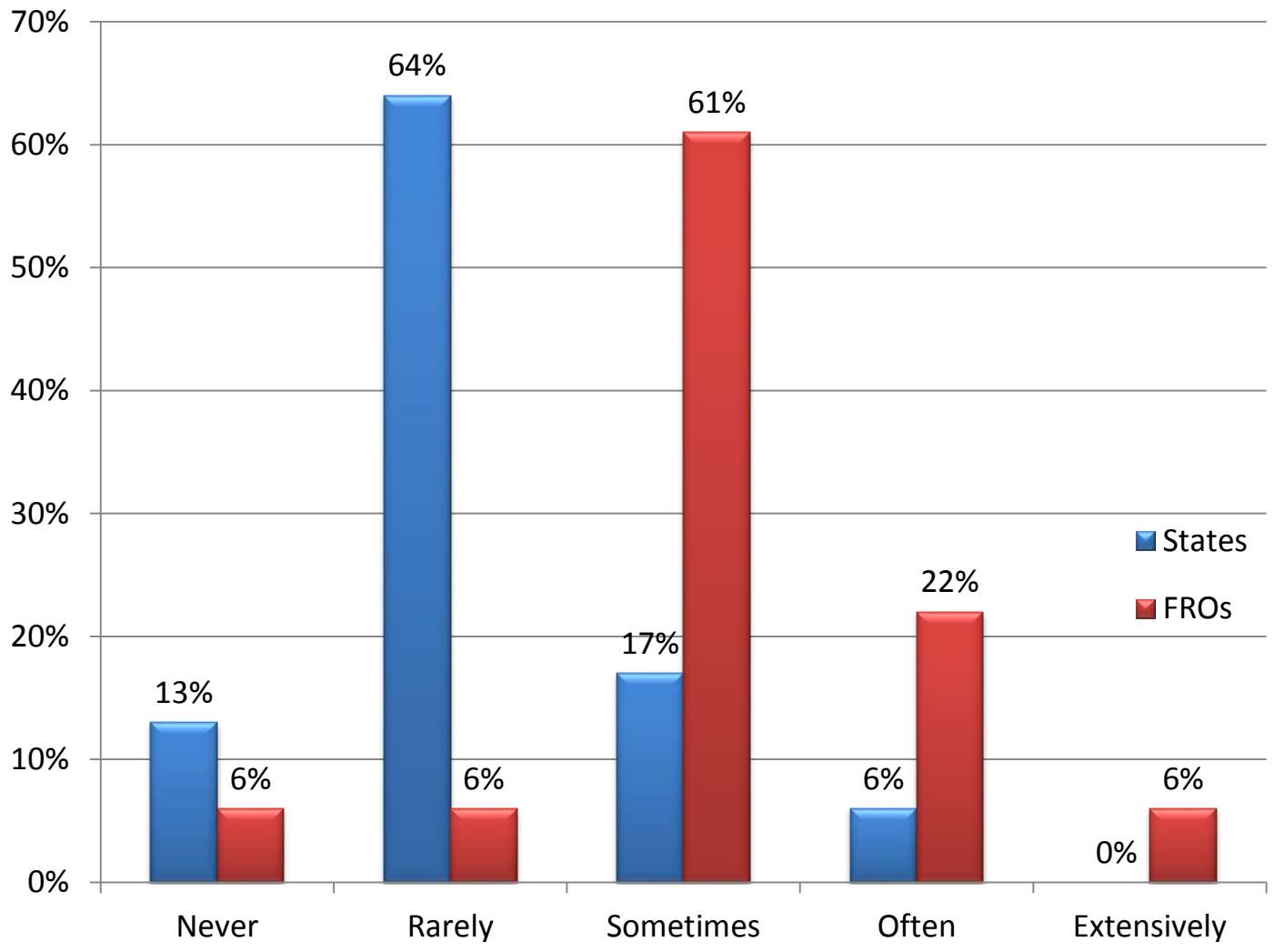
Availability of Data

State Data Collection on Custody Relinquishment to Obtain Behavioral Health Services



- Lack of systematic data collection cited as a problem in previous analyses
- Findings on extent have been estimates
- Continues to be a problem with about 2/3 states not collecting data specifically on relinquishment for behavioral health treatment
- Some improvement found since over 1/3 now collect some data

How Often it Occurs – Frequency



- Relinquishment for treatment is occurring less frequently than in the past
- States – Most reported it now occurs rarely, none extensively, 6% (13 states) never
- FROs – Most reported sometimes

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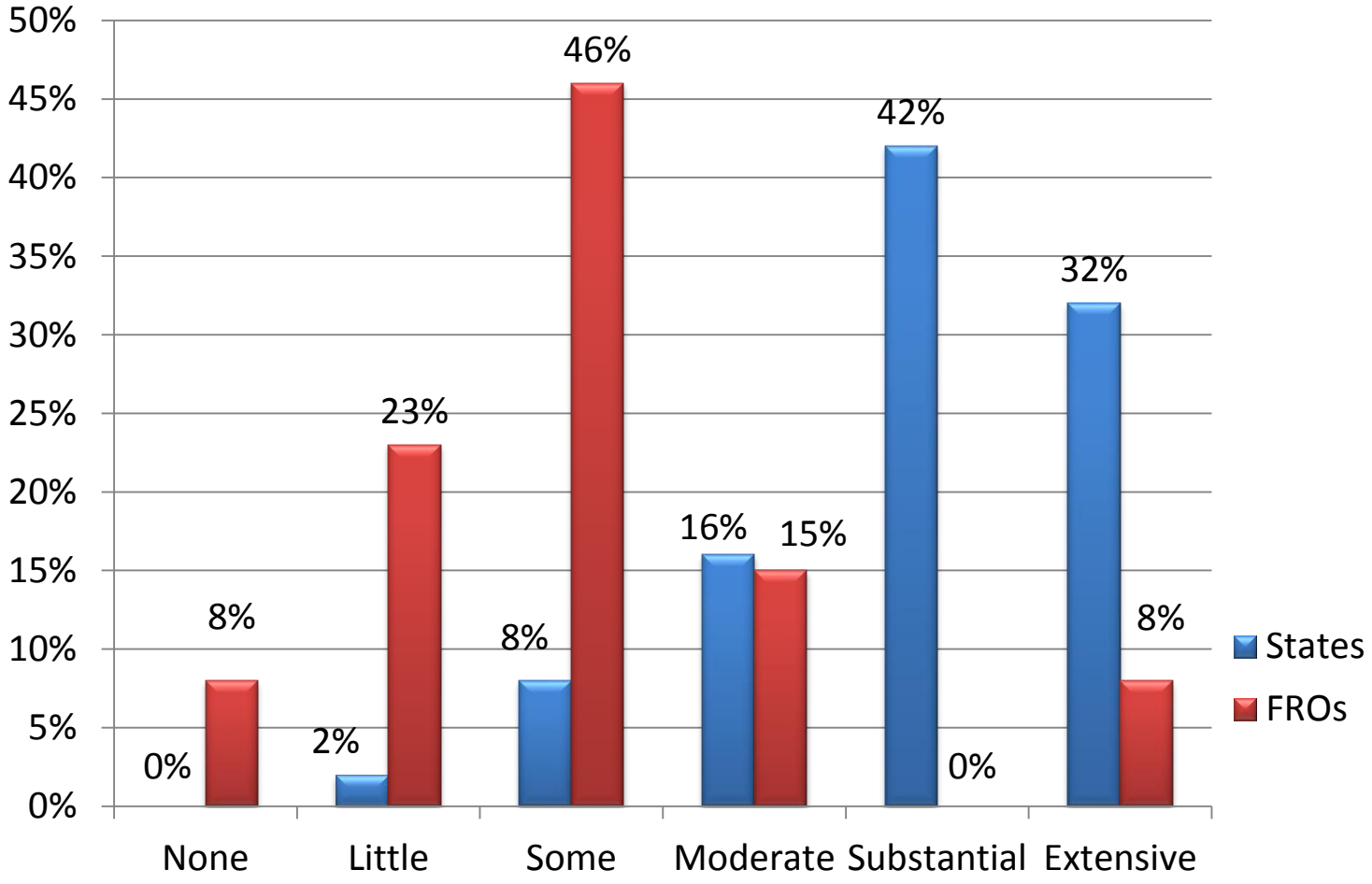
Progress in Reducing Relinquishment for Behavioral Health Services



- Positive movement in reducing relinquishment for treatment since Bazelon report in 2000
- States mean rating – 7.4 Substantial
- FROs mean rating – 3.4 Some

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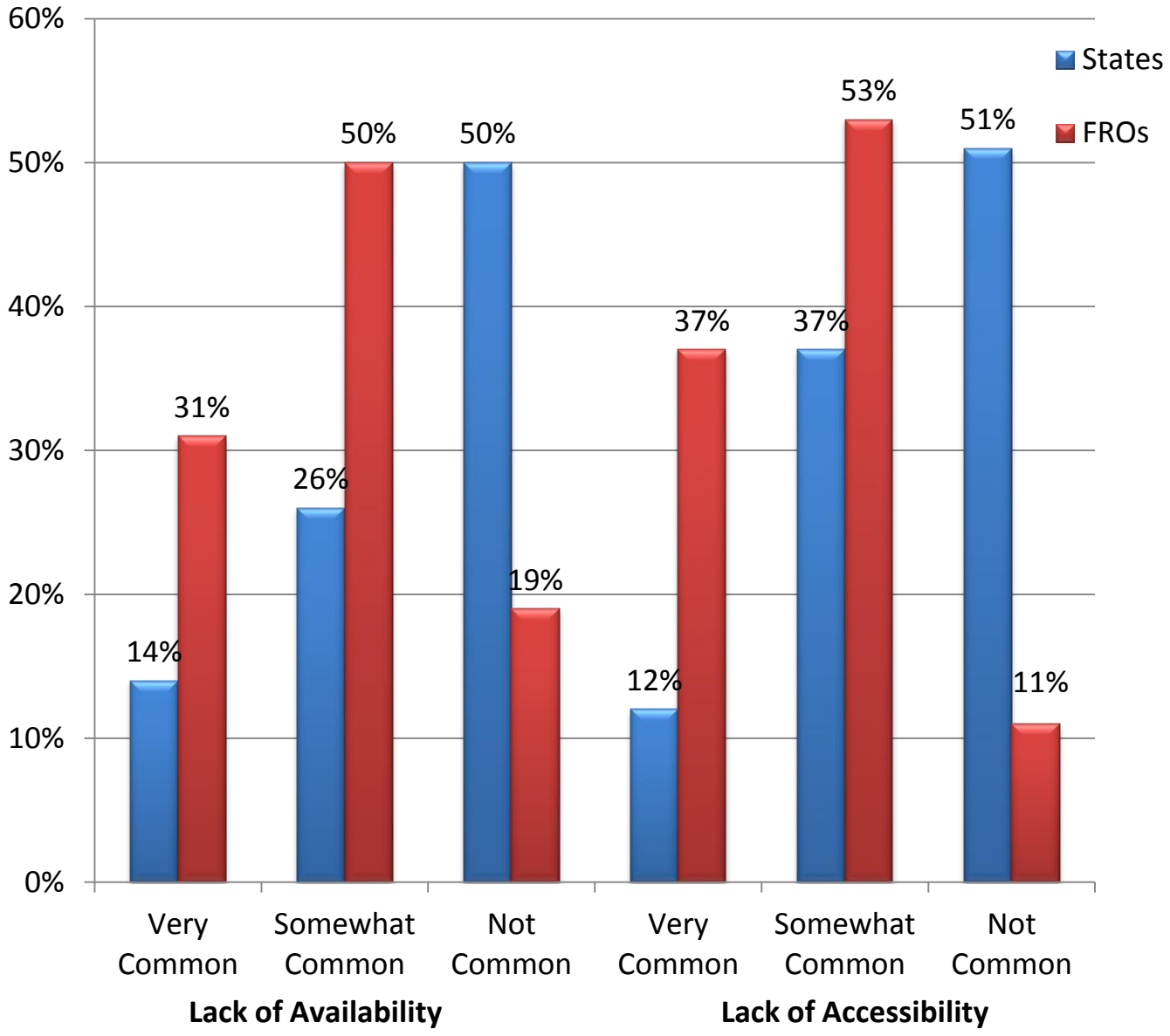
When and Why it Occurs

- Severity and complexity of child's behavioral health condition:
  - So severe that children or adolescents are judged to be a danger to themselves or others
  - May have caused harm or threatened parents, siblings, peers, teachers
  - "Extreme" behaviors, sometime with co-occurring disorders, e.g., developmental disabilities
  - Need for high levels of supervision make it difficult for parents to meet their needs – feel exhausted, hopeless, fearful for safety
- Parents and providers may believe that treatment in a secure setting, e.g., a residential treatment center (RTC), is the best (or only) option for ensuring safety of child, family, and community

Three Primary Reasons: HCB Services, Payment, Courts

1. Causes related to HCB services
   - Lack of availability and/or accessibility
   - Not successful in keeping child in the home and community safely
2. Causes related to payment mechanisms for high-cost services (both HCB services and residential)
   - Private insurance
   - Public insurance (Medicaid and State Children's Health Insurance Program - CHIP)
   - Individuals with Disabilities Education Act (IDEA)
3. Causes related to juvenile courts
   - Judges commit children into custody for residential services

Reasons: Issues with HCB Services



- Ranked second as a reason
- States – Between somewhat common and not common
- FROs – Somewhat common
- Could be lack of investment, lack of leveraging available federal and state financing streams, budget cuts
- Could be insufficient capacity, wait lists, uneven availability across state (e.g., gaps in rural, frontier areas), shortages of professionals, stringent eligibility requirements, etc.
- Without HCB services for treatment and safety, residential treatment may be seen as only option with risk of relinquishment

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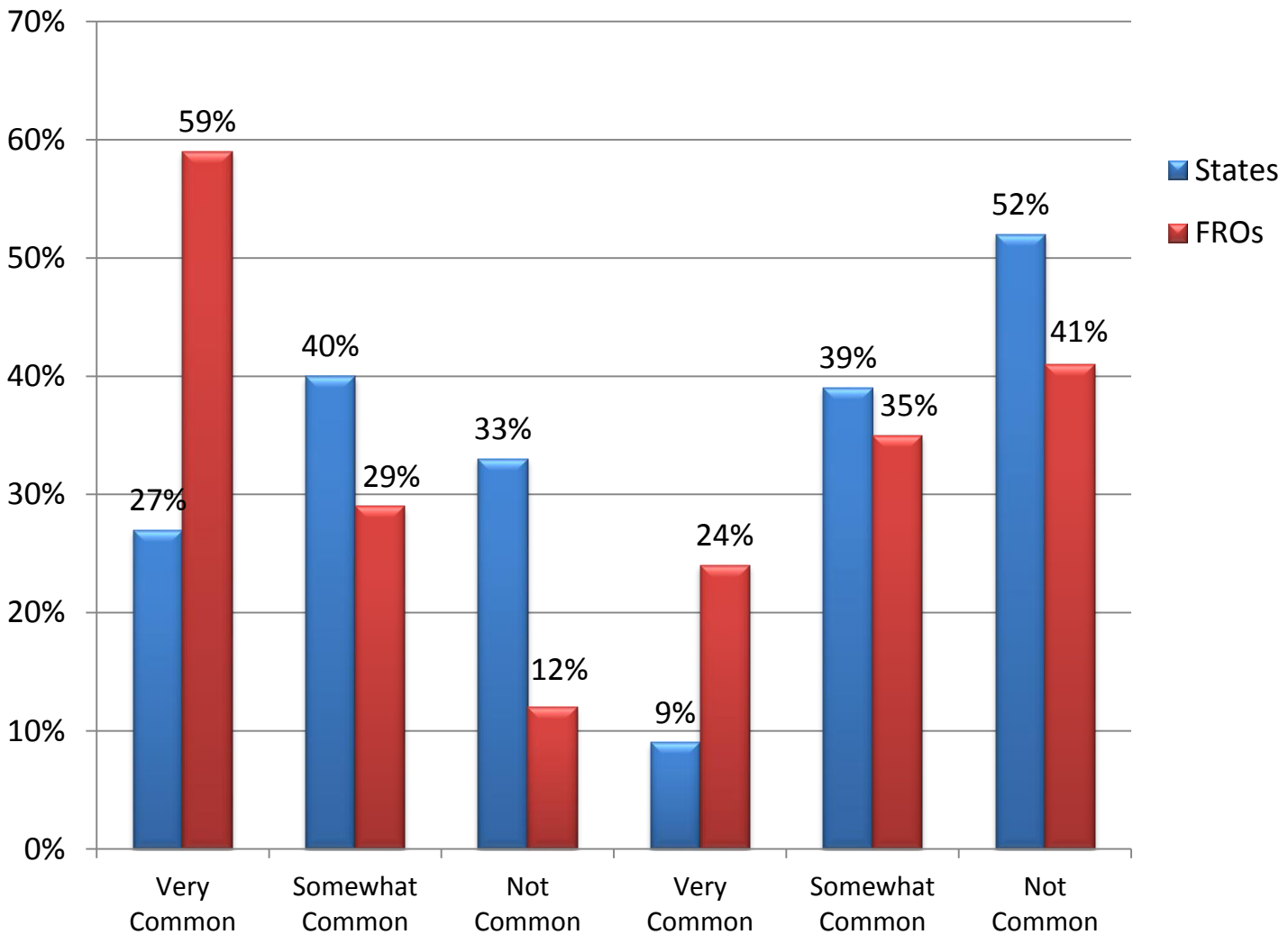
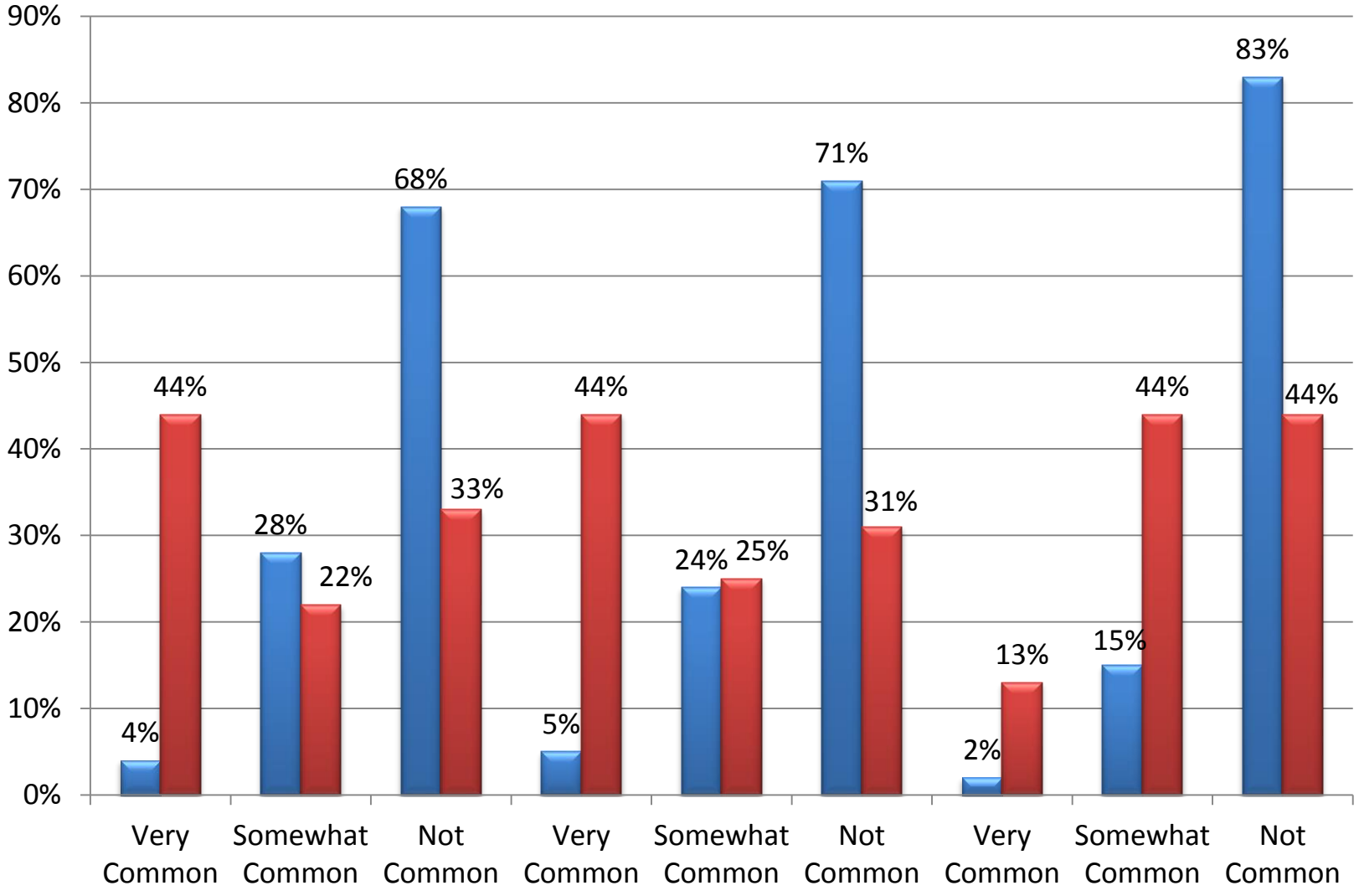
Reasons: Payment Issues Private Insurance



- Seen as most problematic by states and FROs
- Intensive HCB services and residential treatment are either not covered or coverage is inadequate (67% states, 88% FROs)
- May exhaust insurance benefits (less common than inadequate coverage)
- Even with parity legislation requiring equal coverage for health and behavioral health (Mental Heath Parity and Addiction Act of 2008)
- May give up custody to qualify for typically richer benefit package in public insurance (Medicaid) or state agency funds
- Middle class families may be more at risk with poor coverage and high deductibles and co-pays

Reasons: Payment Issues Public Insurance



- Ranked lowest as a cause, especially by states (68% reported not common)
- Medicaid tends to have more robust benefits than private insurance plans, but coverage of intensive HCB services varies across states, and managed care approaches may create barriers to accessing Medicaid or CHIP-financed services by limiting scope or duration

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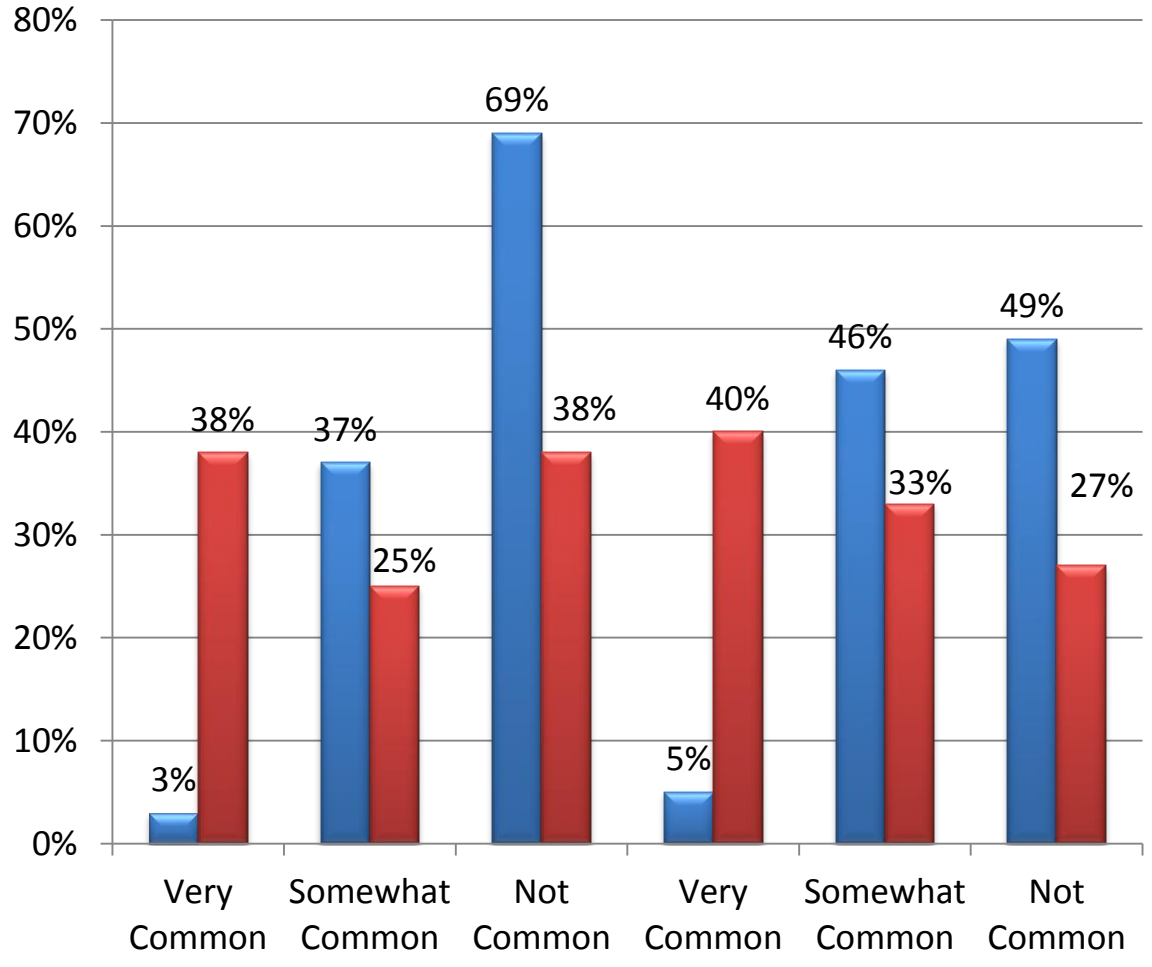
Reasons: Payment Issues IDEA

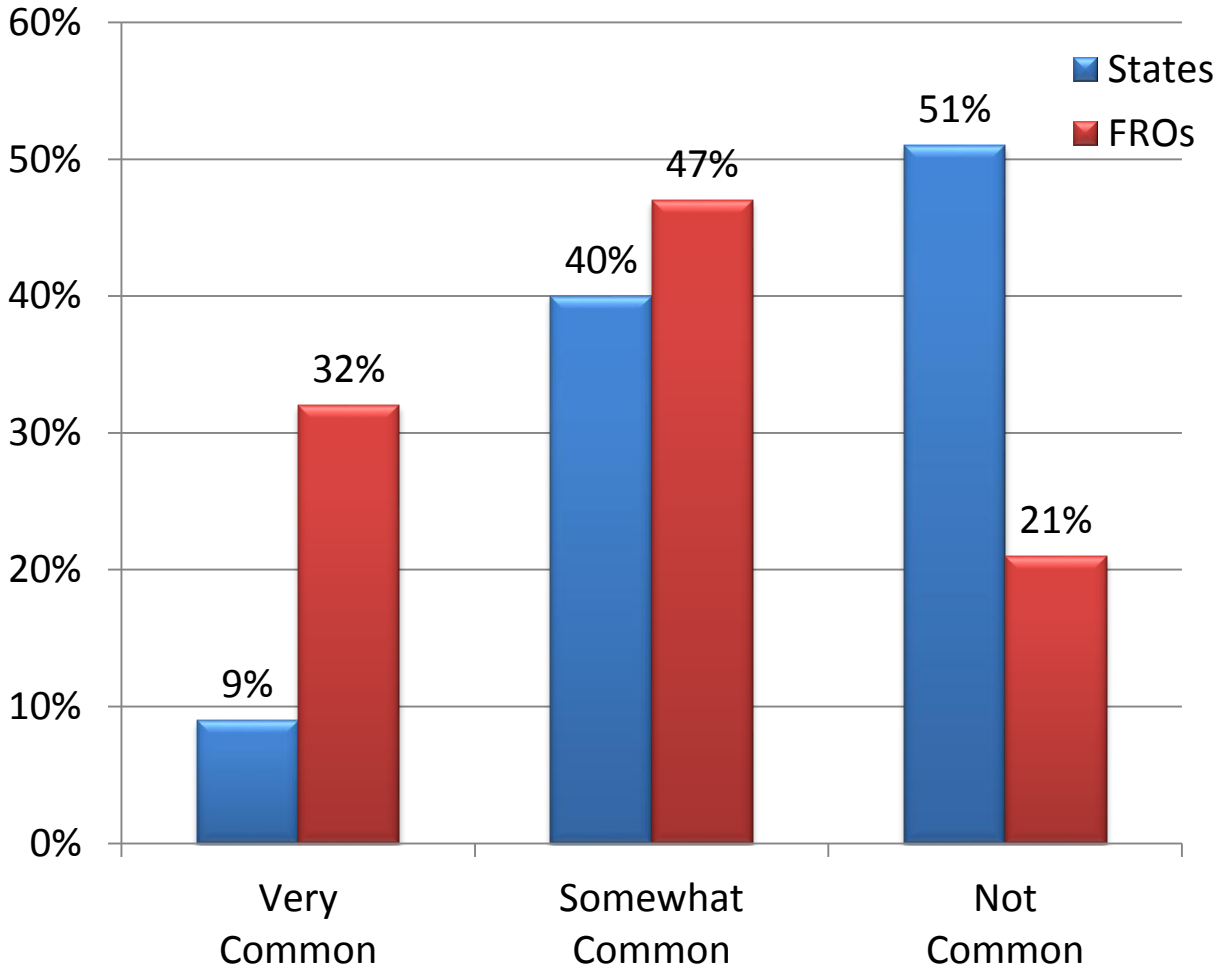


- Ranked third as a cause
- Supposed to provide a free public education and special education and "related services" to children with disabilities
- Varying definitions of what services and supports constitute related services
- SED is reportedly under-identified
- School districts reported to be reluctant to pay for costly intensive HCB services or residential treatment
- Plans under Section 504 of Rehabilitation Act do not entitle children to HCB services, only school accommodations

Children with SED are Not Identified

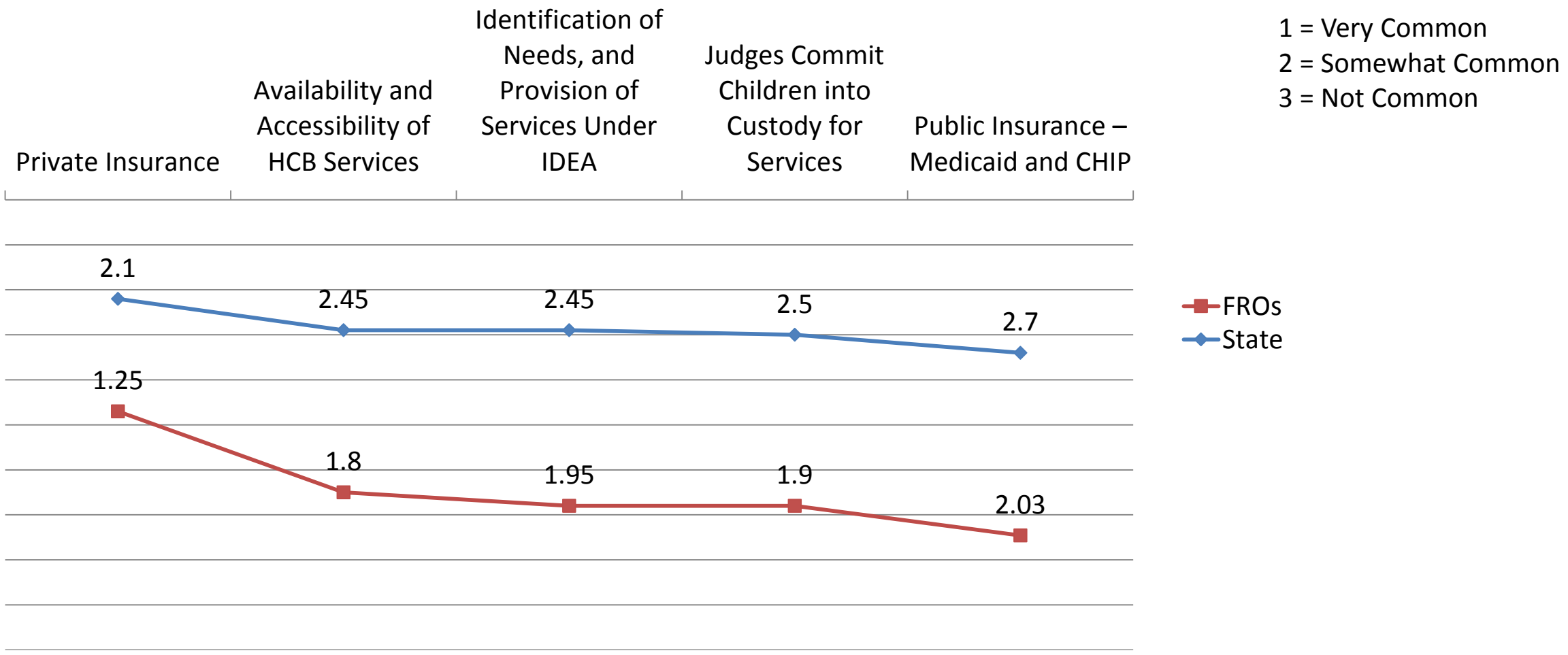
Inadequate Funding for Behavioral Health Services through IDEA

Reasons: Courts Judges Commit Children to Residential Treatment



- Ranked fourth out of the five reasons
- Reported by most states to be not common or somewhat common
- After an arrest, parents or providers may request behavioral health services as part of a disposition, and the court may then order behavioral health services
- Most frequently residential treatment
- May be done without input from behavioral health professionals
- May be done without knowledge of available HCB services or pathway to access them

Mean Rating of Reasons for Custody Relinquishment



1 = Very Common
2 = Somewhat Common
3 = Not Common

- FROs rate all causes as more common than states
- However, same rank order for causes as states

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Strategies to Eliminate Custody Relinquishment

1. Strategies to directly address custody relinquishment
2. Strategies to expand HCB services

NEED BOTH

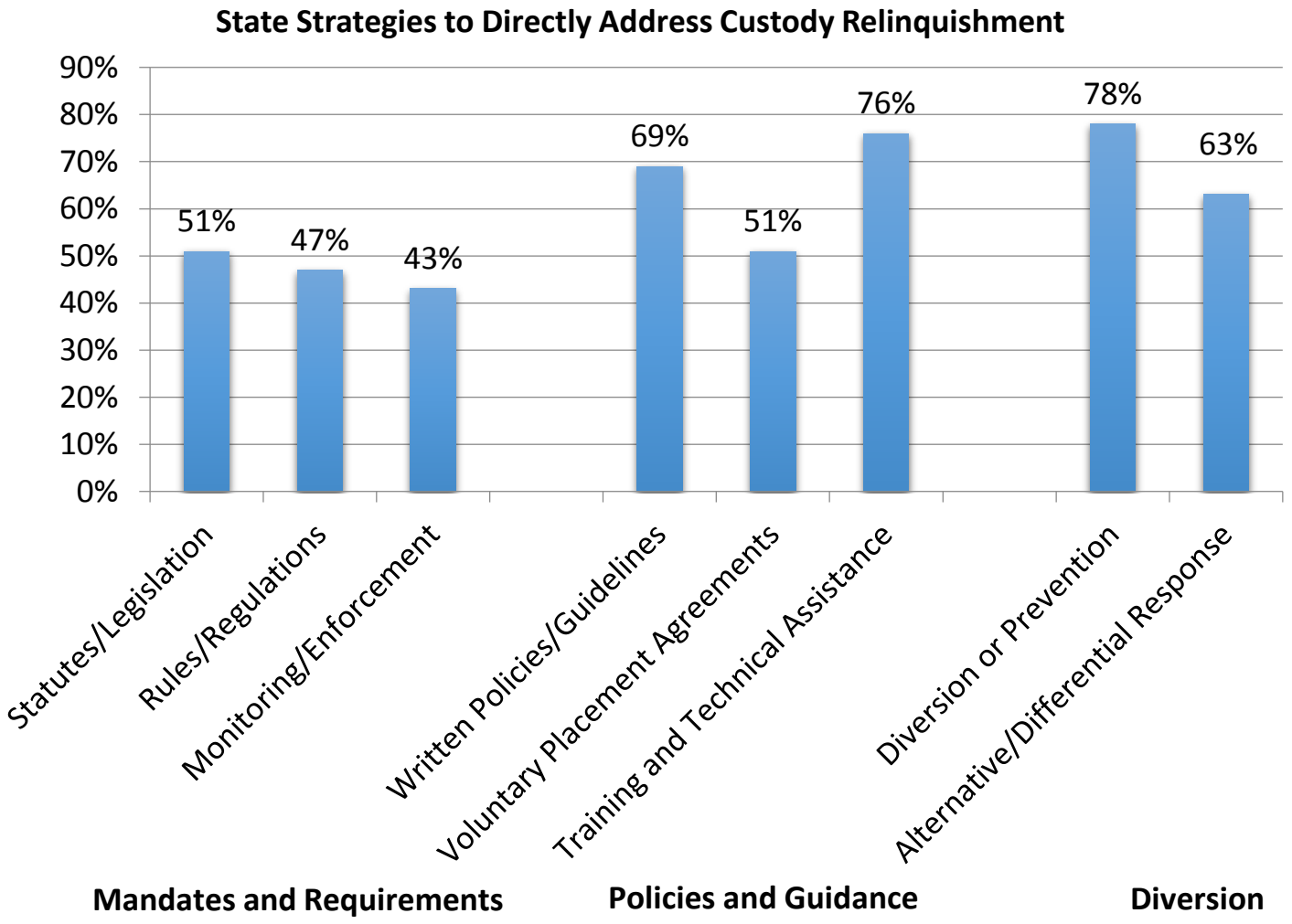
"Just banning the practice closes one door without opening another." (Stine, 2005)

State Strategies to Directly Address Custody Relinquishment

Three Categories:

1. Mandates or Requirements
   - Statutes/Legislation
   - Rules and Regulations
   - Monitoring and Enforcement
2. Policies and Guidance
   - Written Policies or Guidelines
   - Voluntary Placement Agreements
   - Training and Technical Assistance
3. Diversion
   - Differential/Alternative Response
   - Review Processes

State Strategies to Directly Address Custody Relinquishment (cont.)



Overall, nearly 90% states reported using at least one strategy

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State Strategies to Directly Address Custody Relinquishment (cont.)

Mandates

- GAO found 13 states with statutes, now 26 states
- 8 more states with regulations
- Total of 67% with one or both
- Least common strategies

Policies

- Voluntary Placement Agreements (VPAs) used as option in 41% states
  - Parents retain degree of control and rights
  - Considered preferable since legal ties are not severed
  - Still require entry into child welfare system that is designed for abuse and neglect with court reviews, etc.
- Executive orders, policy manuals, guidelines with specific procedures

State Strategies to Directly Address Custody Relinquishment (cont.)

Diversion

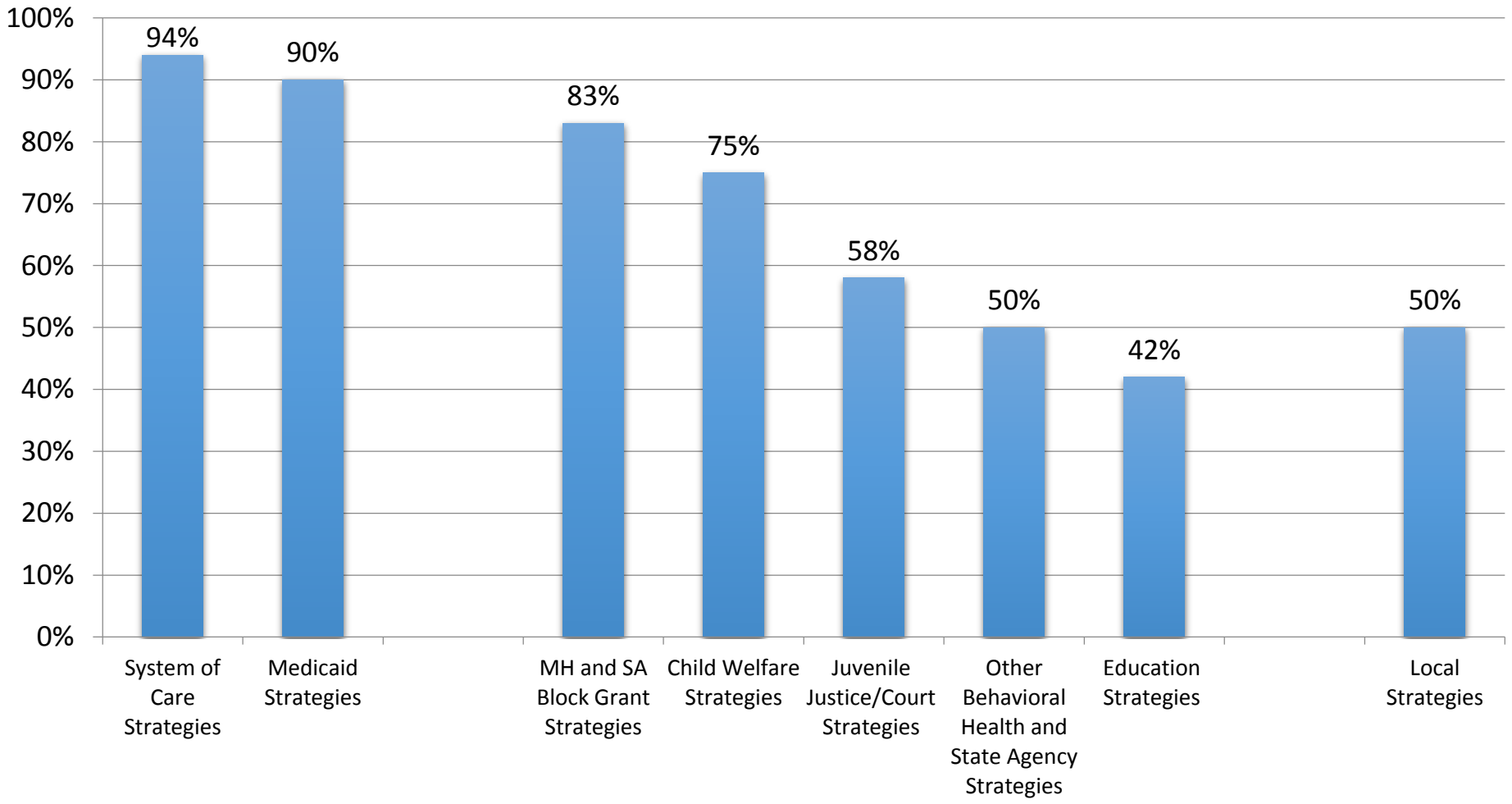
- Most common strategies
- Procedures and protocols, e.g., multi-agency review teams and specific programs for diversion from custody
- Differential, alternative, multitrack, dual track response, allows tailored services whether or not maltreatment is substantiated without custody relinquishment

State Strategies to Expand and Finance HCB Services

Four Categories:

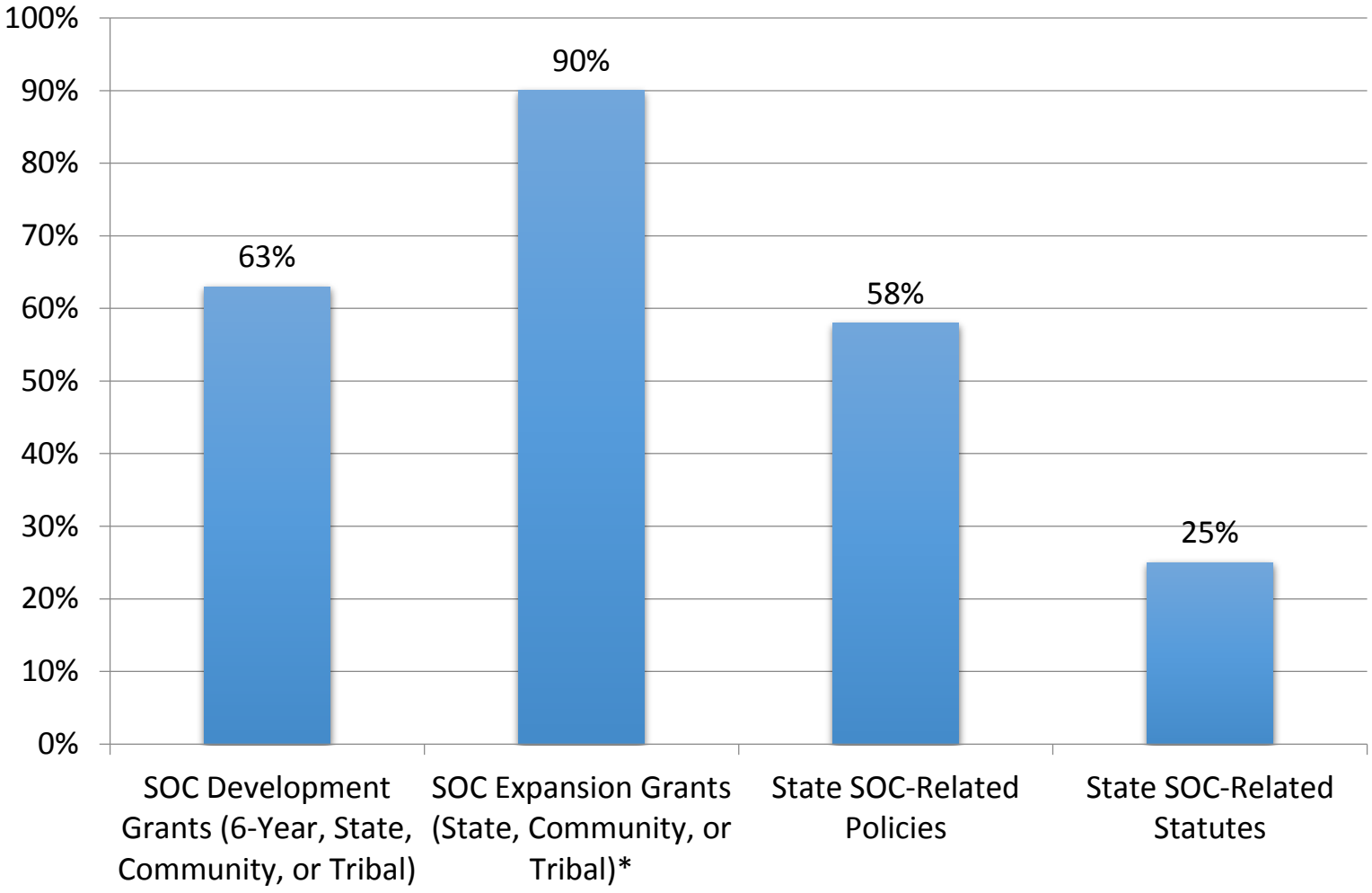
1. System of Care (SOC) Strategies
2. Medicaid Strategies
3. Cross-System Strategies
   - Mental Health and Substance Abuse Block Grants states
   - Child welfare strategies
   - Juvenile justice strategies
   - Education strategies
   - Other behavioral health and state agency strategies
4. Local Strategies

State Strategies to Expand HCB Services (cont.)



- SOC and Medicaid strategies are the most frequently used
- Mental Health and Substance Abuse Block Grants and child welfare are the next most common strategies reported
- Initiatives and funds from other child-serving agencies are used less frequently
- Local initiatives and funds were reported by half of the states

System of Care Strategies



- SOCs provide a comprehensive array of HCB services and supports
- SAMHSA invested in building SOCs in states and communities to provide comprehensive array of HCB services and supports
- Started with 6-year SOC development grants
- Documented positive outcomes and return on investment
- Led to SOC expansion grants, currently 4-year grants to expand and sustain SOCs
- 94% states reported SOC strategies
- More than half have state SOC-related policies, some have statutes

*5 States Tribal Expansion Grants Only

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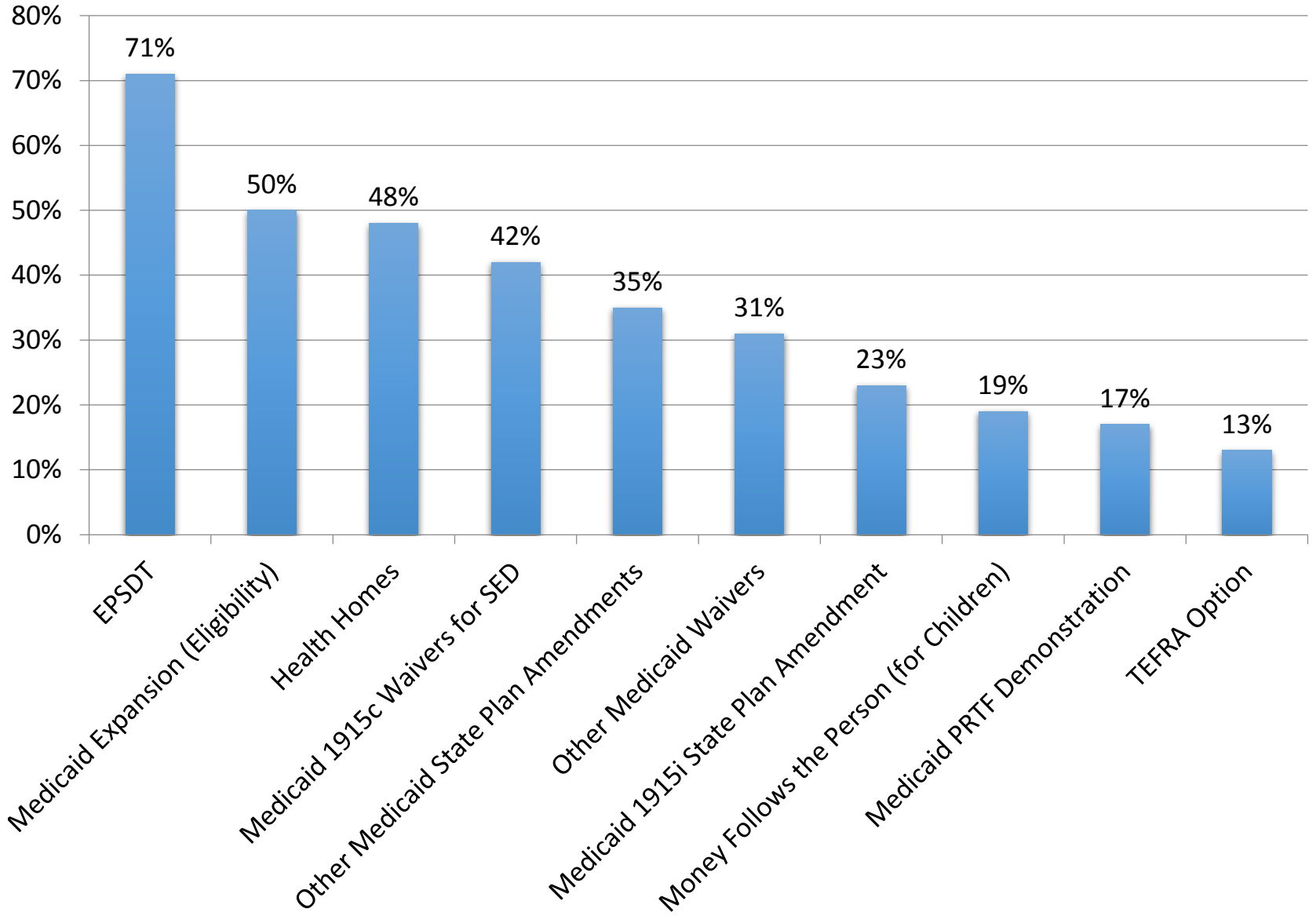
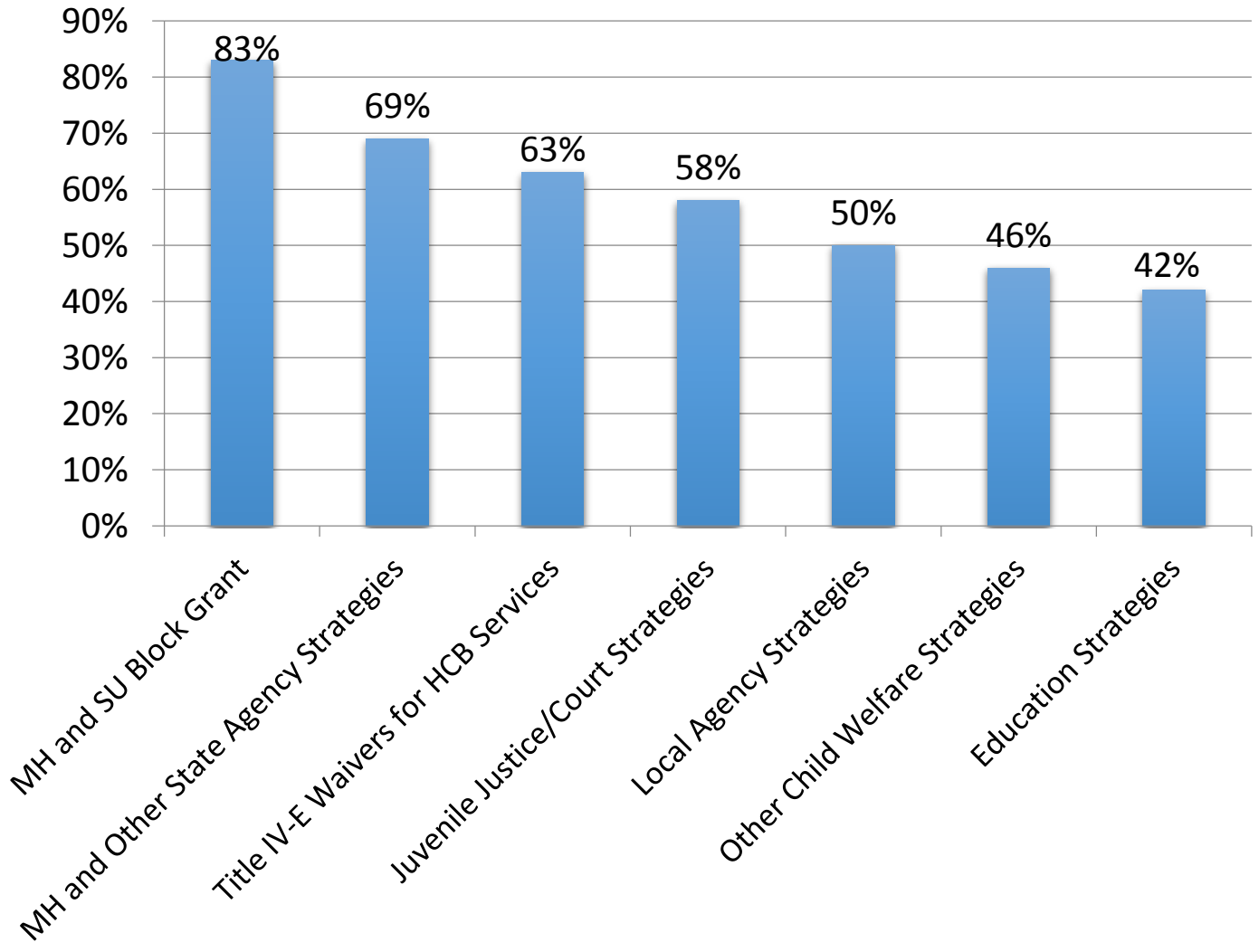
Medicaid Strategies



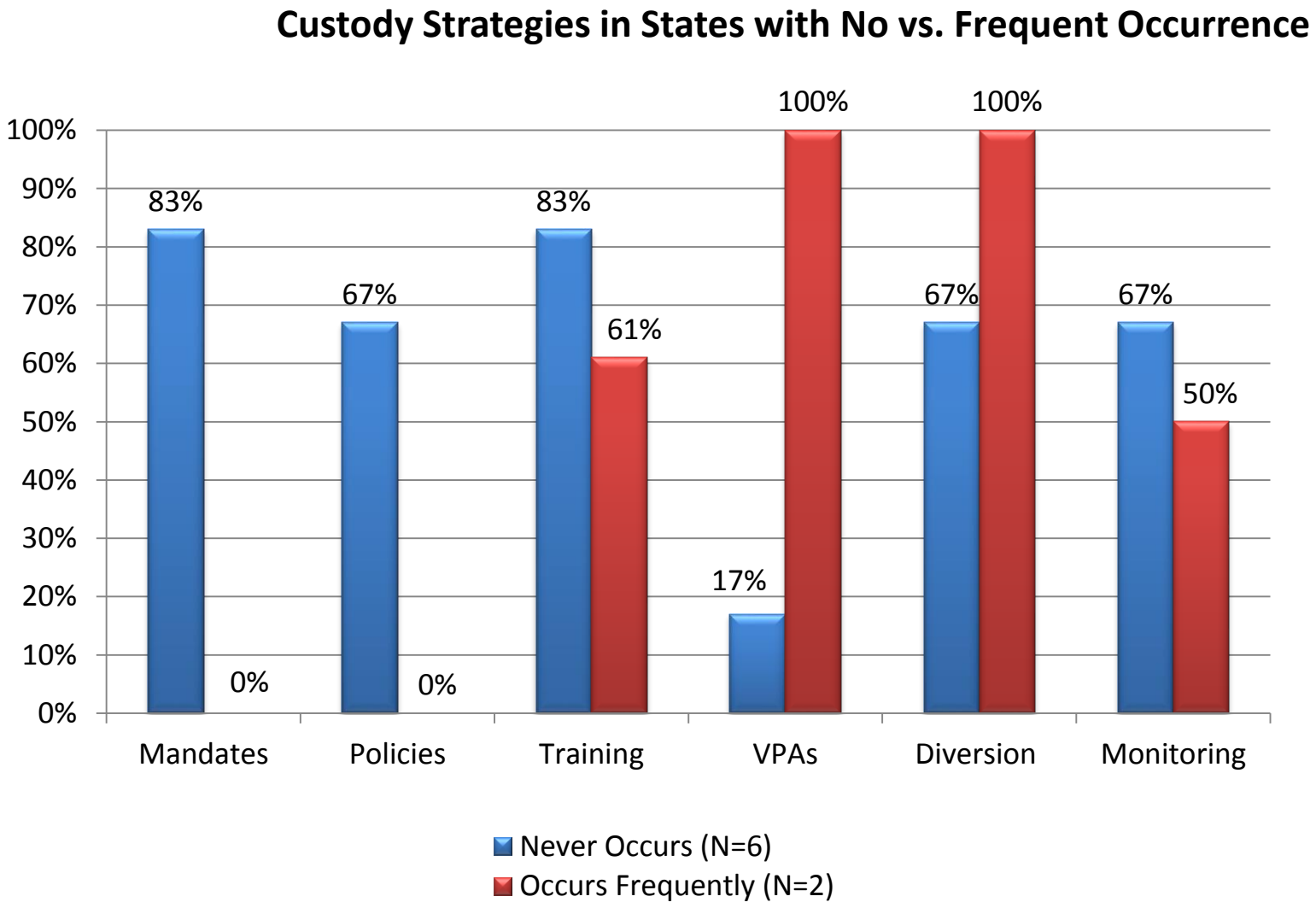
- 90% use Medicaid to finance/increase availability of HCB services and supports
- EPSDT entitlement is most common, although have been problems with weak behavioral health screening and referral (Requires periodic screening and provision of all needed services, even if they are not included in the state's Medicaid plan.)

Cross-Agency Strategies



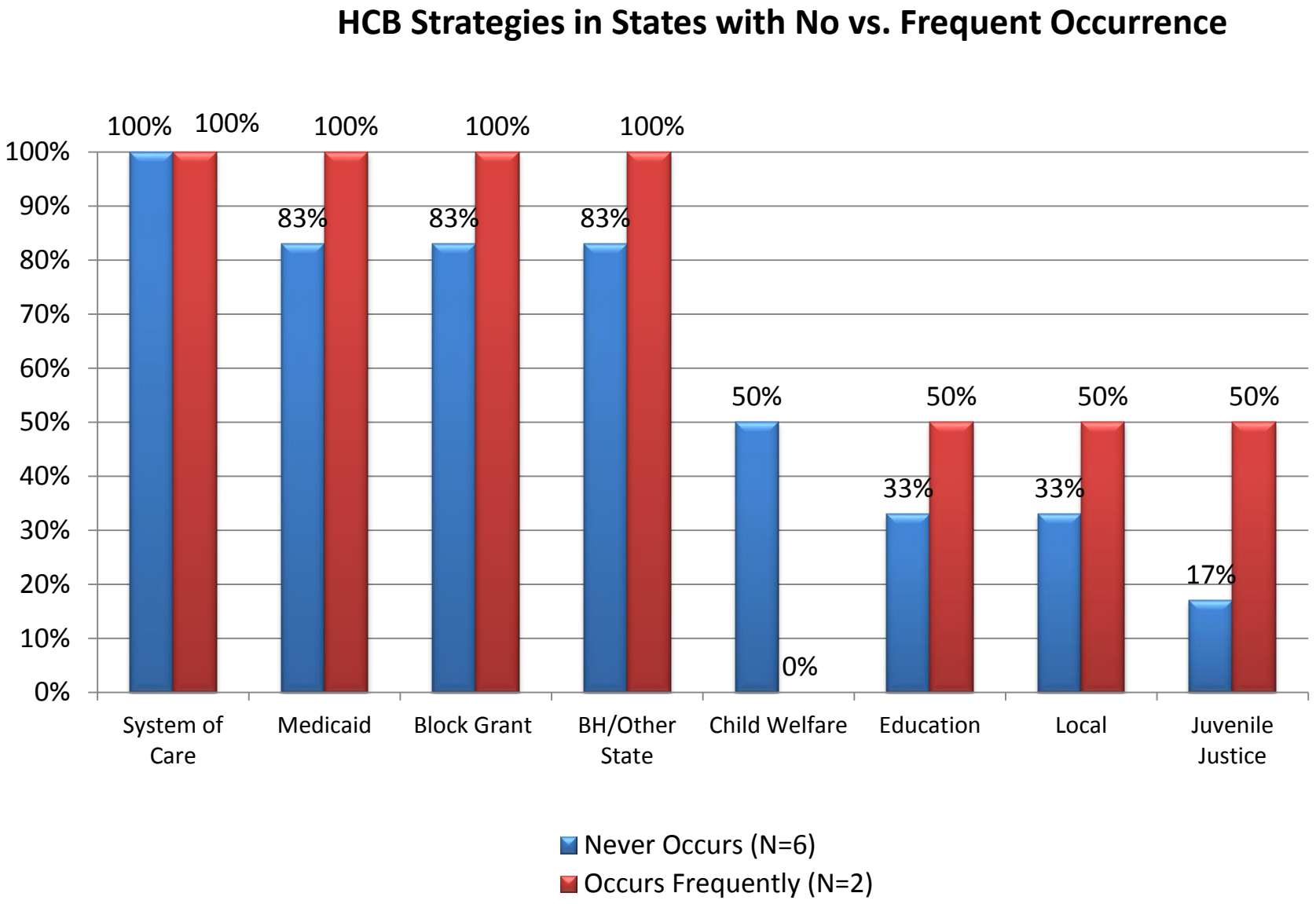
- Most common Mental Health and Substance Use Block Grant
- Previous analysis found Block Grant is used mainly for services not covered by Medicaid or other sources (e.g., peer support, flex funds)
- State mental health and substance use agency funds (general revenue)
- Child welfare IV-E waivers also common

Effective Strategies



- Compared strategies used in states with no occurrence vs. frequent occurrence
- States reporting that custody relinquishment occurs frequently have no mandates (statutes, regulations, or policies), majority of states with no relinquishment have mandates in place
- Suggests that some type of requirement and/or explicit, formalized policy can have an impact
- Somewhat less training related to this practice occurs in states with frequent relinquishment
- The two states reporting frequent relinquishment both have VPAs, while only one state of the six states with no relinquishment uses VPAs. VPAs may not be as significant in eliminating the practice.

Effective Strategies (cont.)



- Strategies used by both groups to build HCB service are fairly consistent
- SOCs, Medicaid, Block Grant, and state behavioral health and other state efforts and funding are the strategies used most frequently
- Child welfare strategies are used in half of states with no occurrence and not at all in states with frequent occurrence
- Juvenile justice, education, and local efforts/funding are used less frequently in both groups

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Effective Strategies (cont.)

- Child welfare agency, behavioral health agency, and FRO interviewees all emphasized that an effective approach requires multiple strategies in each of these areas
- New Jersey example documents how a statewide system of care with an array of HCB services and supports, and residential options as needed are all available, financed, and provided as needed to any child and family

Federal Strategies to Expand and Finance HCB Services

System	Financing Strategy
Child Welfare	• Title IV-E Waiver Demonstration • Title IV-B • Social Services Block Grant
Medicaid	• 1915(c) Home and Community Based Services Waiver • EPSDT • Tax Equity and Fiscal Responsibility Act (TEFRA) (Katie Becket Option) • Health Homes • 1915(i) State Plan Amendment • Medicaid Eligibility Expansion • Money Follows the Person (MFP) Rebalancing Demonstration Grant • 1115 Research and Demonstration Waiver • Psychiatric Residential Treatment Facility (PRTF) Demonstration • Rehabilitation Option • Targeted Case Management
State Children's Health Insurance Program (CHIP)	• CHIP Benefits Expansion
Behavioral Health Grants	• SOC Development Grants (Children's Mental Health Initiative) • SOC Care Expansion Grants (Children's Mental Health Initiative) • Mental Health and Substance Abuse Block Grants • Now is the Time Healthy Transitions (HT) Grants
Education	• Individuals with Disabilities Act (IDEA) • Safe Schools/Healthy Students Grants
Juvenile Justice/Courts	• Office of Juvenile Justice and Delinquency Prevention (OJJDP) Formula Grants
Legislation	• Mental Health Parity and Addiction Equity Act • Patient Protection and Affordable Care Act • 21st Century Health Cures Act

Recommendations to Directly Address Custody Relinquishment

- *Implement Mandates* – Prohibit custody relinquishment solely to obtain behavioral health services through statutes, rules/regulations coupled with monitoring and enforcement.
- *Implement Diversion Strategies* – Implement protocols for responding to situations with a risk of custody relinquishment for behavioral health services to identify alternatives and remove barriers to care.
- *Provide Training* – Train key constituencies (agencies, courts, etc.) on requirements, policies, and protocols that address custody relinquishment for behavioral health services and options for obtaining treatment without relinquishment. Train families and FROs on their rights and options.
- *Use VPAs* – Create a VPA mechanism that allows the state to provide and finance services temporarily without transfer of legal custody.
- *Prevent Penalties for Families* – When it occurs, ensure that parents are not charged with abandonment, placed on child abuse and neglect registries in the absence of maltreatment, or are subject to any other types of penalties.

Recommendations to Directly Address Custody Relinquishment (cont.)

- *Collect Data on Custody Relinquishment* – Track frequency of custody relinquishment for behavioral health services (and other non-maltreatment reasons), why it occurred, and what strategies or services could have prevented it. Use data to better understand the extent to which the practice is being used, for what reasons, and potential solutions.
- *Work with Psychiatric Hospitals* – Implement procedures to work with inpatient psychiatric hospitals to connect them with SOCs offering intensive HCB treatment services and supports post discharge to reduce referrals for residential treatment and reduce psychiatric lockouts.
- *Involve Family Members and Youth in Problem Solving* – Involve family and youth organizations and leaders in identifying the circumstances that lead to custody relinquishment and what measures and strategies they recommend to eliminate the practice.

Recommendations to Increase Availability, Access, and Financing of Intensive HCB Services

- *Implement Comprehensive SOCs* – Provide resources to implement SOCs broadly across states, communities, tribes, and territories.
  - Provide intensive HCB services and supports, such as intensive care coordination using the Wraparound process, intensive in-home services, mobile response and stabilization, family and youth peer support, respite, etc.
  - Ensure that residential treatment is available to children who meet the clinical criteria for this service, that it is used to achieve specific short-term treatment goals, and that it is linked to intensive HCB services in SOCs for ongoing treatment.

- *Use Existing Entitlements* – Maximize the use of existing entitlements to ensure access and payment for behavioral health services.
  - Strengthen the use of the Medicaid EPSDT entitlement to screen for behavioral health conditions and to then provide all needed behavioral health services.
  - Strengthen enforcement of IDEA requirements to identify and meet the service needs of children with behavioral health conditions.

Recommendations to Increase Availability, Access, and Financing of Intensive HCB Services (cont.)

- *Identify Payment Sources for Services* – Ensure that payment sources are available to cover the costs of intensive HCB services and residential treatment when indicated, so that children and families receive services based on clinical need. May include:
  - Ensuring that these services are covered under Medicaid through state plans, waivers, state plan amendments, and other authorities
  - Ensuring that medical necessity criteria do not inappropriately restrict payment for intensive behavioral health services
  - Allocating state agency funds to pay for services not in the benefit packages of Medicaid or commercial insurance or to serve children who do not qualify for Medicaid
  - Redirecting resources currently being spent by child-serving systems on high-cost, out-of-home services to lower-cost HCB services and identifying new resources to expand SOCs
  - Providing data on the effectiveness and return on investment in intensive HCB services across child-serving agencies to support the allocation of funds

Recommendations to Increase Availability, Access, and Financing of Intensive HCB Services (cont.)

- *Work with Commercial Insurers* – Reach out to encourage coverage for intensive HCB under private insurance plans. Provide data on the effectiveness and return on investment in intensive HCB services and supports.
- *Involve Family Members and Youth* – Involve family and youth organizations and leaders in planning, implementing, and financing HCB services and supports to determine their needs; barriers to accessing and financing care; and the effectiveness of strategies to increase availability, access, and payment for services.

Strategies to Address Custody Relinquishment by State

	Mandates or Requirements			Policies and Guidance			Diversion	
State/ Territory	Statutes/ Legislation	Rules/ Regs	Monitoring/ Enforcement	Written Policies/ Guidelines	Voluntary Placement	Training/TA	Diversion/ Prevention	Differential Response
Alaska		X	X	X	X	X	X	X
American Samoa		X	X	X	X	X	X	
Arizona		X	X	X		X		X
California		X				X	X	X
Colorado	X	X	X	X	X	X	X	X
Connecticut	X	X	X	X		X	X	X
Delaware		X	X	X		X	X	X
District of Columbia			X	X		X	X	X
Florida				X			X	X
Georgia				X	X	X	X	X
Hawaii	X	X	X	X	X	X	X	X
Idaho	X			X	X			
Illinois	X			X		X	X	
Indiana		X	X	X	X	X	X	X
Iowa	X	X		X	X			
Kansas						X	X	X
Kentucky	X					X	X	X
Louisiana		X			X	X	X	X
Maine	X	X	X	X	X	X	X	X
Maryland	X	X		X	X	X	X	X
Michigan				X		X	X	
Minnesota	X			X	X	X		
Mississippi	X		X	X	X	X	X	

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	Mandates or Requirements			Policies and Guidance			Diversion	
State/ Territory	Statutes/ Legislation	Rules/ Regs	Monitoring/ Enforcement	Written Policies/ Guidelines	Voluntary Placement	Training/TA	Diversion/ Prevention	Differential Response
Missouri	X		X	X	X	X	X	X
Nebraska			X	X		X	X	X
Nevada					X	X	X	X
New Hampshire	X	X		X		X	X	X
New Jersey	X	X	X	X		X	X	
New Mexico							X	
New York			X	X	X	X	X	X
North Carolina	X			X			X	X
North Dakota	X	X		X	X	X	X	
Ohio			X		X	X	X	X
Oklahoma							X	
Oregon	X	X	X	X	X	X	X	X
Pennsylvania	X	X				X		
Rhode Island	X		X	X	X		X	X
South Carolina		X			X	X		X
Tennessee	X	X	X	X	X	X	X	X
Texas	X	X	X	X		X	X	
Utah	X		X	X	X	X	X	X
Vermont	X	X	X	X	X	X	X	X
Virginia	X	X		X	X	X	X	X
Washington							X	
West Virginia						X	X	X
Wisconsin	X			X	X	X	X	X
Wyoming	X	X		X		X	X	

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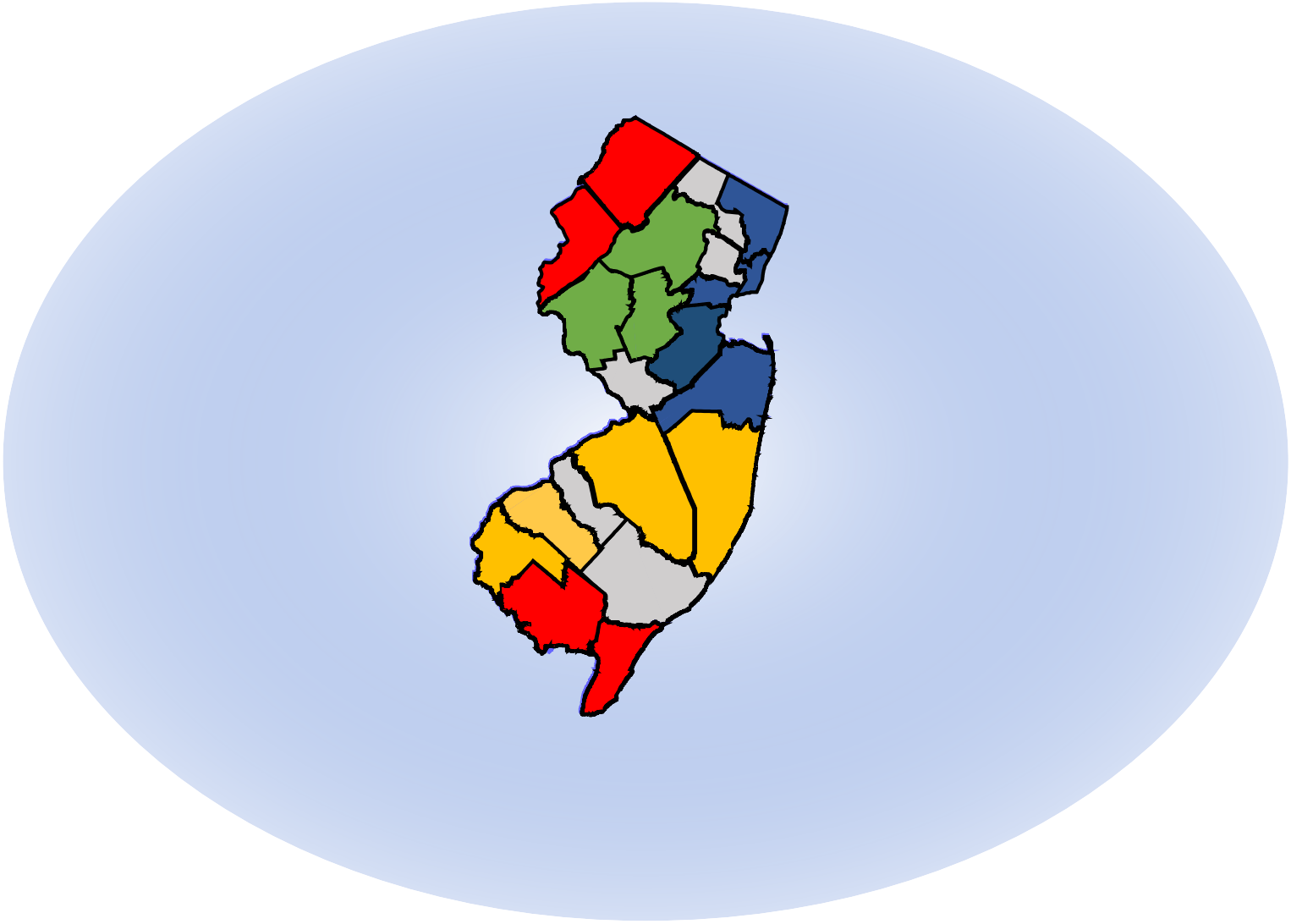
New Jersey



Summary of Children's Initiative Concept Paper

The Children's Initiative concept operates on the following abiding principles:

- The system for delivering care to children must be restructured and expanded
- There should be a single point of entry and a common screening tool for all troubled children
- Greater emphasis must be placed on providing services to children in the most natural setting, at home or in their communities, if possible
- Families must play a more active role in planning for their children
- Non-risk-based care and utilization management methodologies must be used to coordinate financing and delivery of services

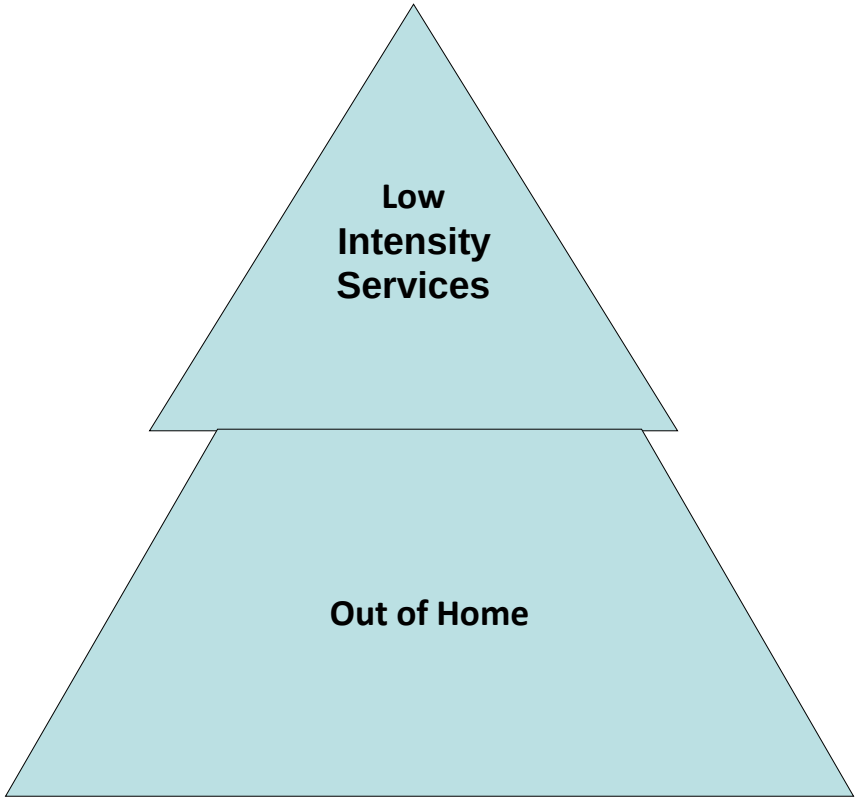
The New Jersey Concept Paper January 2000

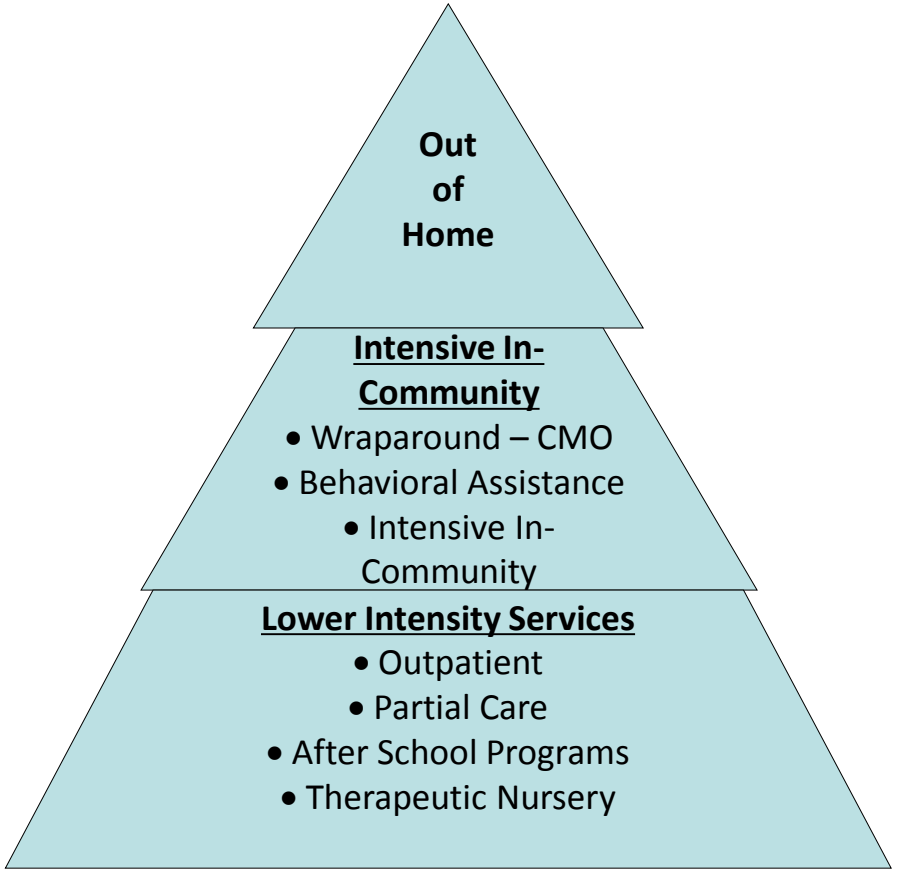
- Increase access and availability of in home services and supports
- Outlined a path to move away from overreliance on both child welfare and juvenile justice systems as the front door of the behavioral health system
- Increase and simplify access to both urgent and emergent services and supports
- Created a single point of access to care and supported utilization management to address clinical necessary services

Structural Changes

- Moved the front door to access, responsibility and resources from child welfare and juvenile justice to the behavioral health system (which has grown to the system of care)
- The role of Medicaid and sustainable funding
- Created a Medicaid alike number
- Focused on Clinical Necessity not ability to pay
- Created strategies around both braided and blended funding
- Supported Family Support and Youth Partnerships
- Created both local and statewide feedback loops

Overuse of Deep-End Services





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New Jersey Access to Care Pre SOC

Child Welfare

- Required Child Welfare involvement
- Required the signing over custody and/or voluntary placement agreements

Juvenile Justice

- Family Crisis Units and Family Crisis Petitions
- Formal charges and detention/probation engagement and court orders for treatment

Acute Care

- Inpatient connection to child welfare for payment of residential
- Long length of stay in hospitals

New Jersey Children's System of Care

- Access through single point of access – 24 hour access
- Clinical necessity established through 3 mechanisms
  - Independent Needs Assessment
  - Mobil Response and Stabilization
  - Needs assessment by engaged mental health provider
- Payment for any services are blind to the parent/youth and young adult
  - Medicaid for youth who meet fiscal or clinical criteria
  - New Jersey Behavioral Health Carve Out

New Jersey Children's System of Care Overview

The New Jersey Children's System of Care serves:

- Behavioral health: Youth with moderate and complex needs, entire New Jersey population
- Behavioral Health Home
- Child welfare: Youth with child welfare involvement and a treatment need
- Developmental/Intellectual Disabilities: Youth eligible for services based on regulatory definition of functional impairment
- Substance use: Youth who have Medicaid or are underinsured and have a treatment need

Department of Children and Families
Division of Children's System of Care (CSOC)

Policy Development
Manages and Approves Provider Network
Funder; contracts directly with agencies
BH Carve Out; Providers bill on fee for service basis

Rutgers UBHC Training and Technical Assistance --Trains All System Partners, Families

Contracted System Administrator (ASO+)

Single Point of Entry and Access to Care 24/7
Triage, Utilization Management
Care Coordination
Authorizes Services
Non risk based
Hosts CSOC's MIS (EHR and Data)

Children's Interagency Coordinating Council (CIACC)-One per county (21)-local planning bodies

Family Support Organizations
Family-led peer support and advocacy for parents/caregivers and youth group

Mobile Response & Stabilization Services
Crisis response and planning; 24/7/365 within 1 hour

Care Management Organization
Utilizes wraparound model to serve youth and families with moderate and complex needs; designated health home entity

Physical Health Integration

Child Family Teams

Dept. of Human Services Division of Medical Assistance and Health Services (Medicaid)

Dept. of Human Services Division of Mental Health and Addiction Services

Dept. of Human Services Division of Developmental Disabilities

Populations Served are youth (and their families) with:

- Behavioral health challenges
- Substance use challenges
- Intellectual/developmental disabilities
- Autism

Youth with **multisystem involvement:
child welfare and/or **juvenile justice**

Other Authorized Services includes but is not limited to:

- Biopsychosocial Assessments
- In home Clinical/Therapeutic
- Out of Home Care (OOH)
- Partial Hospitalization
- Substance Use Services
- In home Behavioral for I/DD youth
- Family Support Services for I/DD Youth
- Non Medical Transportation
- Interpreter Services
- Outpatient
- Assistive Technology

CANS ASSESSMENT TOOL
Utilized in Triage, for Treatment Planning and Outcomes Tracking

- 1115 Waiver-Children's Supports Waiver, I/DD and SED
- State Plan Amendments
- Targeted Case Management-CMO
- Psych under 21 Benefit-OOH Programs
- Rehabilitative Option-MRSS, IIC/BA, Out of Home
- State Option to Provide Health Homes
- Flex Funds

State and Federal Appropriations

Title XIX and Title XXI

Client Case Placement

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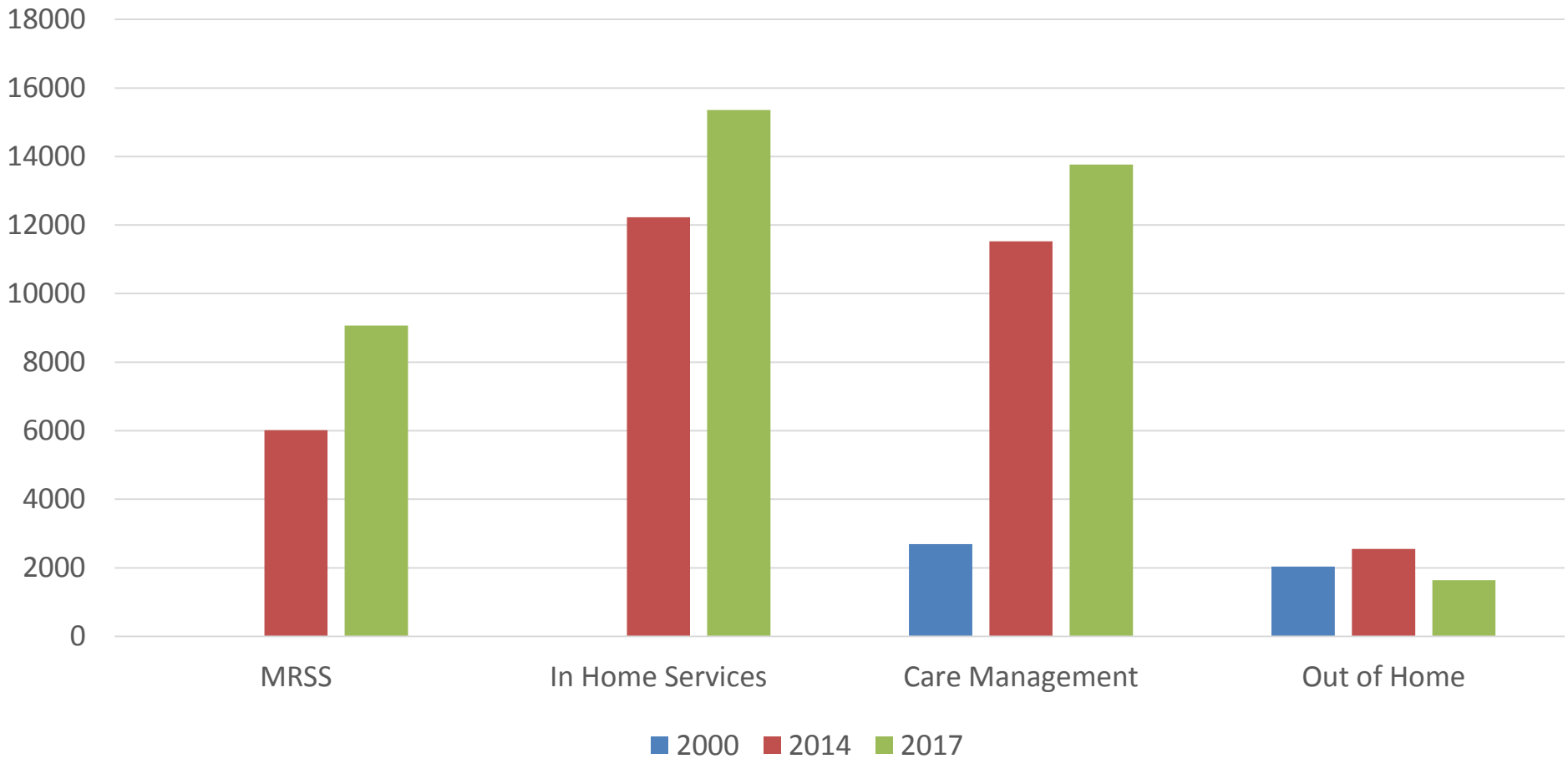
New Jersey Children's System of Care Utilization Information



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For More Information on New Jersey

New Jersey's Children's System of Care

www.state.nj.us/dcf

PerformCare

www.performcarenj.org

Thank You.

SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

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1-877-SAMHSA-7 (1-877-726-4727) ● 1-800-487-4889 (TDD)

SAMHSA
Substance Abuse and Mental Health Services Administration

National Technical Assistance and Evaluation Center for

Systems of Care

Improving Child Welfare Outcomes through Systems of Care: Overview of the National Cross-Site Evaluation

Improving Child Welfare Outcomes through Systems of Care: Overview of the National Cross-Site Evaluation

November 2010

U.S. Department of Health and Human Services
Administration for Children and Families
Administration on Children, Youth and Families
Children's Bureau

Table of Contents

List of Figures

List of Graphs

This report was prepared under the direction of Janice Shafer, Bethany Miller, and Pamela Johnson (retired), Children's Bureau, Administration on Children, Youth, and Families, by the National Technical Assistance and Evaluation Center for Systems of Care (Center). The Center is operated by ICF International under Contract GS23F-8062H, Order Number 03Y00371501D.

This report is based on the 5-year cross-site evaluation of the implementation of the *Improving Child Welfare Outcomes through Systems of Care* demonstration initiative in nine grant sites representing 18 communities. This report would not have been possible without the contributions and support of the many individuals and organizations in those communities who are dedicated to meeting the needs of children and families.

The research for and writing of evaluation reports described in this overview reflect the collective efforts of Center staff including Nicole Bossard, Daniel Cantillon, Gary DeCarolis, Sarah Decker, Colleen Janczewski, Emily Niedzwiecki, Jill Sanclimenti, Jing Sun, and Erin Williamson. This team benefited from the leadership of Aracelis Gray, Janet Griffith, and Mary Sullivan. Any conclusions noted in this report reflect Center staff's analysis and interpretations of the evaluation data and do not necessarily reflect the viewpoints of the Federal Government.

In addition to evaluating and documenting the outcomes of the demonstration initiative, Center staff provided technical assistance to the grant communities on all aspects of planning, developing, implementing, evaluating, and sustaining their Systems of Care change efforts. At the conclusion of the demonstration program, Center staff work closely with the Children's Bureau to generate and disseminate knowledge about child welfare-led systems of care implementation. For further information, contact Janice Shafer at:

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U.S. Department of Health and Human Services, Administration for Children and Families. *Improving Child Welfare Outcomes through Systems of Care: Overview of the National Cross-Site Evaluation* (Washington, DC: U.S. Government Printing Office, 2010).

1. Improving Child Welfare Outcomes through Systems of Care

In 2003, the Children's Bureau funded nine demonstration grants to test the efficacy of a system of care approach to improving outcomes for children and families involved in the child welfare system and to address policy, practice, and cross-system collaboration issues raised by the Child and Family Services Reviews.[1] This 5-year initiative, entitled *Improving Child Welfare Outcomes through Systems of Care*, focused on infrastructure development to strengthen the capacity of human service agencies to support families involved in public child welfare through a set of six guiding principles:

- Interagency collaboration.
- Individualized, strengths-based care.
- Cultural and linguistic competence.
- Child, youth, and family involvement.
- Community-based approaches.
- Accountability.

Concurrent with the initiative, the Children's Bureau supported a national evaluation of the demonstration program. This overview summarizes the initiative and its cross-site evaluation, presents key findings related to the implementation process and outcomes, and highlights lessons learned and conclusions.

1.1 Child Welfare Driven Systems of Care Initiative

A system of care approach has shown promise for improving outcomes for children and families in other settings, such as the field of mental health (Lourie, Stroul, & Friedman, 1998; U.S. Department of Health and Human Services, 2007). The Children's Bureau initiative explored its potential for addressing the needs of children and families involved in the child welfare system. The Children's Bureau built upon the systems of care work of the mental health field, which promoted services that were family-centered, individualized, culturally competent, and coordinated. To succeed as a framework for change, systems of care had to be tailored to the specific mandates and challenges of the child welfare system to protect children from abuse and neglect while also preserving and strengthening families who are typically involved in the system involuntarily.

There is increasing recognition that to meet the complex and multifaceted needs of children and families, child welfare agencies cannot work in isolation. The Children's Bureau Systems of Care initiative facilitated grant communities to work collaboratively with other child- and family-serving systems toward shared goals of safety, permanency, and well-being of children and their families. Grant communities were required to develop collaborative governance bodies that brought together representatives from public and private agencies, community organizations, and families involved in the child welfare system.

The demonstration was intentionally structured with an emphasis on assessment and planning. The initial year of the grant was designated for a strategic planning process in which collaborative groups assessed their community's needs and strengths; agreed on a common

1 The Child and Family Services Review is a Federal quality assurance assessment of State child welfare agencies' performance in achieving positive outcomes for children and families. States are assessed for substantial conformity with certain Federal requirements for child protective, foster care, adoption, family preservation, family support, and independent living services. The review process includes a statewide assessment and an onsite review of child and family service outcomes related to safety, permanency, and well-being as well as systemic factors that affect the achievement of positive outcomes.

vision and goals to guide their work; identified the population of children that would serve as the focus of the initiative; and created a strategic plan to promote use of evidence-based and promising practices to support children and families in the child welfare system. To build capacity and create a supportive culture for achieving sustainable, systemic change, the initiative restricted use of grant funds to infrastructure development rather than direct services.

During the demonstration's implementation phase, grant communities were expected to implement policies, procedures, trainings, and programs aimed at infusing and integrating the six systems of care principles into their communities' child welfare agency and related child- and family-serving systems. These activities, in turn, were expected to lead to improvements in case planning, case management, and service delivery—i.e., strengths-based planning that includes families in a meaningful way, coordinated and integrated service delivery, and receipt of culturally appropriate and community-based services. Ultimately, the Systems of Care activities were intended to result in improved safety, permanency, and well-being of children and their families. (See Appendix A for a broad conceptual framework of the Systems of Care initiative.). To promote accountability, each grant community partnered with a local evaluator to monitor and assess the implementation of its specific Systems of Care initiative.

1.2 Systems of Care Communities

The following nine demonstration sites, which represented 18 communities, received 5-year grants by cooperative agreement:

- Contra Costa County Employment and Human Services Department (Contra Costa, California);
- Jefferson County Department of Human Services (Jefferson County, Colorado);
- Kansas Social and Rehabilitation Services (Cherokee and Reno counties, Kansas);
- Clark County Department of Family Services (Clark County, Nevada);
- New York City Administration for Children's Services (Brooklyn, New York);
- North Carolina Department of Social Services (Alamance, Bladen, and Mecklenburg counties, North Carolina);
- Native American Training Institute (Mandan-Hidatsa-Arikara Nation – Three Affiliated Tribal Social Services, Turtle Mountain Child and Family Services, Spirit Lake Social Services, and Standing Rock Child Protective Services, North Dakota);
- Oregon Department of Human Services (Clackamas, Washington, and Umatilla/Morrow counties, Oregon); and
- Pennsylvania Department of Public Welfare (Dauphin and Northumberland counties, Pennsylvania).

The grant communities represented a diverse mix of rural, urban, and tribal settings, and varied in terms of target populations, focus areas, and prior systems of care experience (see Appendix B). Some grant communities identified specific target populations (e.g., children in out-of-home care), while others targeted a broader population of children, such as all children at risk of entering the child welfare system or children already involved in child welfare and related systems. Grant communities could design their Systems of Care initiative and adopt various strategies to meet their particular needs, context, and priorities and to complement ongoing initiatives and reform efforts.

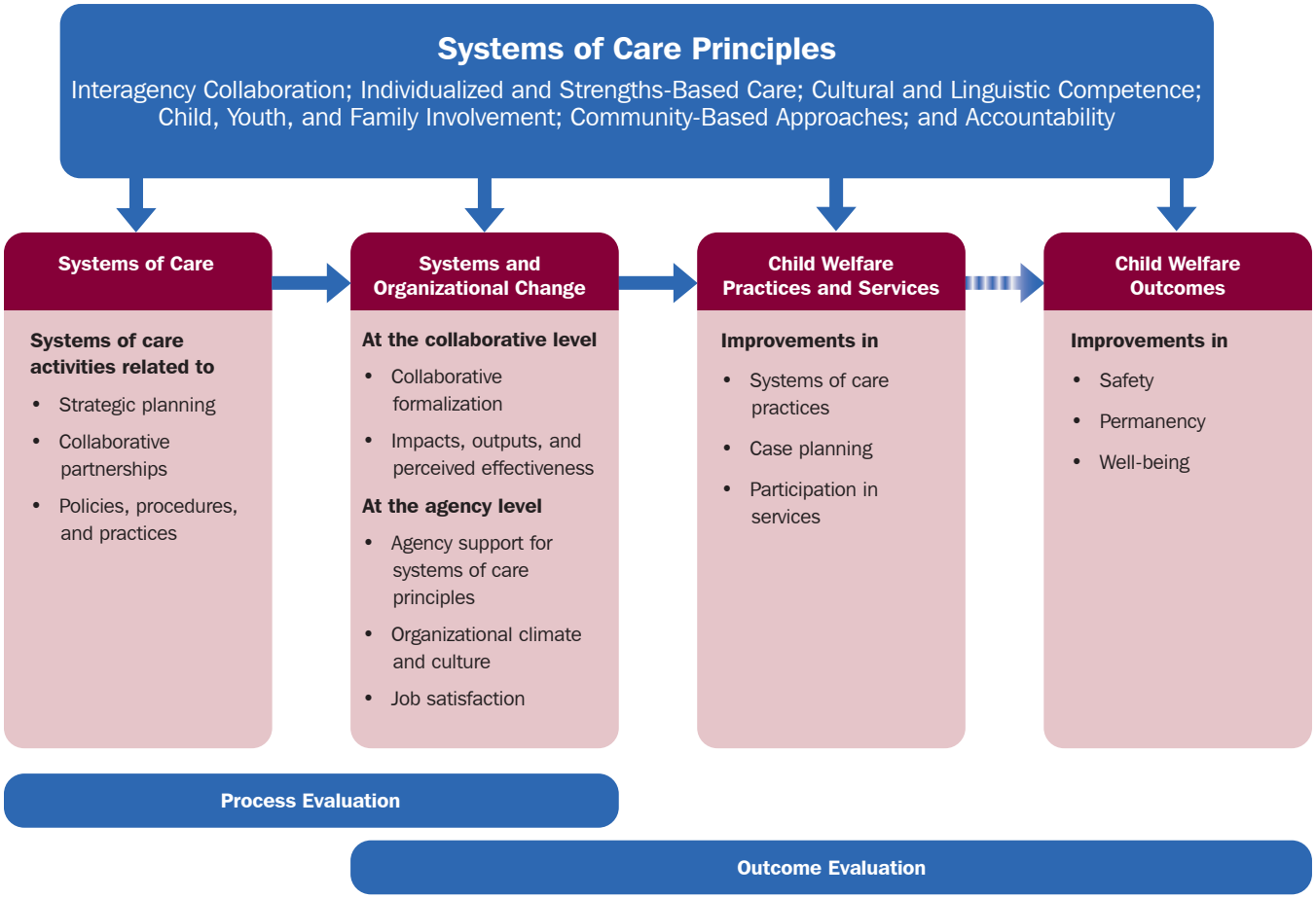
1.3 National Cross-Site Evaluation

Grant communities were supported by the National Technical Assistance and Evaluation Center (Center) funded by the Children's Bureau. In addition to

conducting a national cross-site evaluation of the demonstration program, the Center provided long-term, intensive technical assistance to the grant communities. The Center played a pivotal role in the national systems of care "learning laboratory" by helping to build the capacity and potential for success of grant communities, while documenting results and exploring the facilitators and barriers to effective systems and organizational change (see Resources for a list of Center publications). This innovative approach that combined technical assistance and evaluation within a single center made the evaluation not only a means for assessing program impact, but also a tool to inform technical assistance through ongoing lessons learned.

To fully understand the complexity and issues associated with the implementation and impact of the Systems of Care demonstration initiative, the national evaluation adopted a comprehensive mixed methods approach, which included a process and outcome evaluation component. As illustrated in Figure 1, the evaluation examined grant activities related to strategic planning, collaborative partnerships, policies, procedures, and practices, the corresponding impact such work had on systems and organizational change at the collaborative and agency levels, improvements in child welfare practices and services, and outcomes for children and families.

Figure 1: Systems of Care Evaluation Framework



The national evaluation focused on these primary questions:

1. To what extent has the implementation of Systems of Care led to systems and organizational change?
2. What types of systems and organizational change resulted? What actions and processes were undertaken to create systems change?
3. To what extent has the implementation of Systems of Care led to changes in case practice and service delivery and subsequent changes in outcomes for children and families (i.e., safety, permanency, and well-being)?

To address these questions, the evaluation team designed a study that capitalized on multiple data sources, including:

- Interviews with Systems of Care project directors and other personnel, local evaluators, and child welfare and partner agency staff;
- Focus groups with direct service workers from child welfare and partner agencies;
- Surveys of collaborative members[2] and child welfare agency direct service workers;[3] and
- Case-level data gathered through case file reviews of randomly selected child welfare case files from Systems of Care grant sites.[4]

Data were collected at multiple time points beginning in 2005 and ending in 2008.[5]

1.4 Limitations of the Evaluation

The evaluation had several important limitations:

- Due to the duration of the evaluation and high turnover in collaborative membership and child welfare agency staff, individual survey respondents were not tracked longitudinally, making it difficult to ensure the comparability of the data.
- Due to the small sample size of the individual collaboratives, stakeholder survey data were aggregated across all grant communities, thereby reducing the variability of the findings.
- Different and evolving record-keeping policies and mandates across grant communities made it difficult to interpret whether findings related to cross-site case files were due to case planning and practice changes or changes in record-keeping policies.
- Because the evaluation did not include a quasi-experimental design that "matched" children and families from Systems of Care communities to those who were not receiving this systems change intervention, and because several systems change initiatives were in existence across the grant communities, the evaluation team was unable to definitively link any positive changes in child and family outcomes to the Systems of Care initiative.

Nevertheless, the evaluation provides a valuable foundation for examining the potential for Systems of Care to build capacity and achieve the systems and organizational changes needed to improve the safety, permanency, and well-being of children and families. Although we cannot causally link systems and

2 Collaborative members refer to those individuals who participated on interagency structures that were charged with planning for and guiding the implementation of Systems of Care activities in grant communities. A total of 521 collaborative members participated across three survey time points (2005, 2006, 2008), for an average of 174 at each survey administration.

3 A total of 1,722 direct line staff participated in surveys across three time points (2005, 2006, and 2008), for an average of 574 at each administration.

4 The national evaluation team reviewed child welfare case files twice over the evaluation period: 2003 (639 case files) and 2007 (650 case files). Grant sites chose 65–80 cases at random from the total pool of cases reflecting their target population.

5 Data sources and data collection methodology are described in detail in the technical appendices of *Organizational and Systems Change Resulting from the Implementation of Systems of Care*, available at http://www.childwelfare.gov/management/reform/soc/communicate/initiative/ntaec.cfm.

organizational changes to changes in child and family outcomes, we are able to infer, through the triangulation of data from multiple sources, how Systems of Care efforts and activities may have had an impact on individual-level outcomes. Further, valuable lessons learned for future systems of care efforts can be drawn from the successful experiences as well as the challenges of the demonstration grant communities.

This *Overview of the National Cross-Site Evaluation* synthesizes key findings of the evaluation of the Systems of Care initiative. Additional reports provide in-depth analyses of critical aspects of the demonstration initiative.[6] *Systems and Organizational Change Resulting from the Implementation of Systems of Care* is the primary technical evaluation report. Other reports provide:

- Comprehensive case studies of the implementation of Systems of Care in two exemplary grant communities;
- An in-depth analysis of the role of leadership in Systems of Care implementation; and
- A focused examination of the principle of family involvement across grant communities.

6 Systems of Care evaluation reports are available at http://www.childwelfare.gov/management/reform/soc/communicate/initiative/ntaec.cfm.

2. Infrastructure Development and Capacity Building Processes

To build capacity for systems and organizational change, communities engaged in local infrastructure development and strategic planning activities. Infrastructure development reflected efforts to modify agency organizational structures and align functions, processes, and policies while incorporating systems of care principles (DeCarolis, Southern, & Blake, 2007).[7] Key activities included developing collaborative interagency governance bodies to set directions and provide oversight, building a leadership and management structure to oversee and carry out activities, establishing the goals and overarching vision for the initiative, conducting assessments of community strengths and needs, and identifying coordinated approaches for integrating systems of care principles into agency policies, practices, and procedures.

2.1 Key Elements

Grant communities progressed through initial infrastructure development and planning activities at varying rates. Variations in early progress reflected the presence or absence of a variety of start-up and readiness factors, including:

- Clear understanding of the goals and focus of the Systems of Care initiative;
- Experience with systems of care, cross-system collaboration, and systems reform;
- Strong and consistent leadership; and
- Shared vision for the community's system of care.

As implementation progressed, the following elements also emerged as influential to capacity building processes:

- Dedicated staff and champions; and
- Stakeholder buy-in.

The Systems of Care focus on infrastructure development was central to start-up and implementation.

While the funding announcement clearly emphasized infrastructure development, a few grant communities were slow to make the conceptual shift away from traditional service delivery. With guidance from the Children's Bureau and technical assistance, they were able to make course corrections. The eventual focus on infrastructure was critical to helping grant sites implement systems of care principles across all levels of the child welfare agency and integrate them into sustainable policies, practices, and procedures, as well as into cross-system structures and processes.

The pace of infrastructure development was influenced by grant communities' prior experience and ongoing involvement in systems reform and community collaboration.

Each grant site used a community-based collaborative to plan and implement Systems of Care activities. While some communities formed new interagency bodies, several communities leveraged and built on existing groups of child- and family-serving agencies, adding new members as appropriate, such as family members formerly involved with the child welfare system. Building on existing collaboratives saved time and recruitment efforts, reduced duplication, and leveraged existing relationships. These groups,

7 For more information on infrastructure development, see *Improving Child Welfare Outcomes through Systems of Care: Building the Infrastructure. A Guide for Communities*, available at www.tapartnership.org/docs/improvingChildWelfareThroughSOC.pdf.

however, sometimes had to balance the commitments and priorities of multiple initiatives.

Prior experience with other systems of care initiatives, particularly those targeting children and youth with serious emotional disturbances and their families, helped some community leaders articulate their vision and prepare for implementation. For other communities, however, it created confusion and served as a barrier as participants struggled to differentiate the Children's Bureau initiative from prior systems of care efforts.

Several communities were able to integrate their Systems of Care efforts into ongoing State or county child welfare reform efforts. Frequently driven by the Child and Family Services Review process, these reforms generally focused on family-centered child welfare practice, differential response to meeting the needs of children and families, and increased accountability. Communities were not only able to align systems of care principles with the underlying values of other systems change initiatives but also position the Systems of Care effort to strengthen ongoing reform.[8]

Strong and consistent leadership was critical to success.

Leadership was particularly important given the nature of systems change initiatives to challenge the status quo and do things differently. The important role of leadership was identified at multiple levels. At the agency level, supportive child welfare administrators established a constructive climate for change by demonstrating their commitment to the initiative. Child welfare administrators helped to integrate the vision for Systems of Care within the larger mission of the agency, identified opportunities and resources for integration of the principles, and served as advocates for the initiative with internal and external partners. Project leaders then ensured the initiative's vision was carried forward in day-to-day activities. Effective project leaders, leading from the "middle," were vital to successful planning and implementation.

Given the complex nature of systems change work, a dedicated full-time project director was essential. Experience in the child welfare system and a deep understanding of child welfare issues were important attributes for project leaders to build credibility for Systems of Care and connect the project to the agency's mission.

Many grant communities were challenged to identify the right individual to serve as project director and experienced high turnover in the position. Turnover negatively influenced the progress of start-up and subsequent implementation activities as momentum was lost, decision-making slowed, and collaborative efforts were jeopardized.

Systems change leaders, in collaboration with stakeholders, need to create a shared vision and a clear plan for implementing the vision.

Leaders need a purposeful vision that clearly identifies the direction the organization will take and articulates the anticipated outcomes. Successful Systems of Care leaders were able to communicate the vision to internal and external stakeholders and inspire others to fulfill the vision. Interviews and collaborative member survey data underscore the importance of aligning the vision with the underlying purpose of helping children and families. While some leaders started with their own vision for the initiative, they often recognized the importance of bringing together key stakeholders—including agency partners, child welfare staff, and family members—to refine that vision and develop a strategic plan for moving forward.

8 Detailed examples of how communities implemented Systems of Care within the context of child welfare reforms and other collaborative efforts are presented in *Systems of Care Implementation Case Studies*, available at http://www.childwelfare.gov/management/reform/soc/communicate/initiative/ntaec.cfm.

The leadership study[9] found that during implementation, effective leaders could keep their focus on the big picture. They demonstrated perseverance when push back occurred, but exhibited flexibility to revise action plans as needed to overcome challenges. Consistent communication with staff members, partners, and the community regarding the shared vision and initiative's progress helped keep everyone on track. Through communication, leaders aimed to connect the initiative to the values and priorities of the various stakeholders.

Dedicated positions, champions, and the right staff generated progress.

Hiring or assigning staff dedicated to the day-to-day implementation of specific Systems of Care principles (e.g., family involvement) or activities (e.g., training, community engagement, evaluation) greatly facilitated progress in multiple sites. Tasking specific staff members or committees with planning and coordinating principle-related efforts helped sustain focus on principles, identify resources, overcome barriers to integration, and establish valuable relationships that supported ongoing advancement. Several communities anticipated that the dedicated positions would be sustained beyond the grant's completion.

Communities often credited success to initiative champions at various levels of the organization and among community stakeholders. Passionate about the work, these committed change agents were able to open doors, garner support for the initiative, and serve as valuable resources in times of crisis, such as after a child fatality.

Local evaluators also played an important role in several communities' initiatives. Adopting participatory research approaches, several evaluators contributed to ongoing decision-making and implementation processes. In addition to helping communities develop logic models, set goals, and measure progress, local evaluators shared data to generate stakeholder buy-in and inform initiative directions. This type of meaningful involvement of local evaluators appeared to build community capacity. Communities found it important to select a local evaluator with the right "fit"—i.e., an evaluator who had knowledge of the child welfare system, experience evaluating systems change initiatives, and strong partnering abilities.

The buy-in and support of child welfare agency staff and other stakeholders were important elements of successful Systems of Care implementation.

To encourage buy-in and support, agency leaders conducted outreach and social marketing activities, and held meetings with agency staff and community members in which they not only presented information about Systems of Care and its connection to other ongoing initiatives, but also solicited input. Sharing findings from community needs assessments helped increase commitment and consensus about important issues, while cross-systems retreats provided forums for planning how to address issues. In addition, training on systems of care principles—often held jointly among child welfare staff, partner staff, and family and community representatives—coupled with increased use of a shared language, generated a common foundation for understanding systems of care, supported relationship building among stakeholders, and contributed to buy in.

Child welfare workers are the linchpin to incorporating systems of care principles into case planning and service delivery to meet the needs of children and families, and ultimately enhance outcomes. As such, overcoming resistance and gaining support among frontline workers was critical. Engagement of caseworkers frequently hinged on a "brass ring"—a tangible project component that aided day-to-day practice. In one community, the tangible component

9 For more information, see *Leadership in the Improving Child Welfare Outcomes through Systems of Care Initiative*, available at www.childwelfare.gov/management/reform/soc/communicate/initiative/ntaec.cfm.

was an automated management information system that improved the efficiency of casework documentation. In another, specific protocols for family conferencing meetings helped caseworkers operationalize the principle of family involvement in day-to-day practices. In addition, engagement of middle managers and supervisors was essential so they could model and reinforce systems of care values, communicate relevant policies and procedures, and provide ongoing guidance and support to the frontline staff.

While outreach was frequently emphasized in the early stages of the initiative, findings pointed to the importance of continuing engagement over time to reenergize stakeholders who face competing priorities and to communicate goals and progress to new staff. Leaders noted that recognizing short- and long-term successes and acknowledging the people who contributed to them can help keep stakeholders motivated. Additionally, tracking and sharing data that demonstrate the initiative's impact on outcomes was found to be a powerful tool to sustain stakeholder support.

2.2 Process Considerations

Systems of Care planning and capacity building take time.

While the grant program cooperative agreement provided for a year of planning, the strategic planning process took longer than expected. Many communities needed 1–3 years to develop their strategic plans. In addition, while communities were able to convene collaborative members early in the initiative, it often took several years to strengthen the commitment and trust among the interagency partners and establish the needed infrastructure to support collaborative activities.

Grant communities' readiness for systems change increased over the course of the initiative.

Analysis of stakeholder survey data demonstrated that organizational and community readiness for systems of care generally increased over time in most communities. Readiness was defined as stakeholders' knowledge and support for Systems of Care, leadership in child welfare and partner agencies, and availability of resources and expertise in planning for, implementing, and adapting systems change efforts.

Individual grant communities experienced different developmental trajectories in terms of their readiness to implement Systems of Care. While there was initial variation in readiness and capacity for implementation, these differences were minimized over time. The focus on building grant communities' readiness through planning and technical assistance activities appears to have enabled less ready communities to build their capacity and thereby "catch up" to communities initially more ready to undertake change.

3. Systems and Organizational Change

The national cross-site evaluation explored the effectiveness of a principle-guided system of care approach in creating systems and organizational change and promoting improvements in child welfare practices, case planning, and service provision.

3.1 Systems Change

The national evaluation team defined systems change as changes in interagency partnerships and collaboration and focused on measuring such changes at the collaborative level.

A principle-guided systems of care approach resulted in systems change across child- and family-serving agencies.

Implementation of Systems of Care promoted interagency collaboration and partnerships among child welfare and child- and family-serving agencies. Surveys revealed that overall, community stakeholders demonstrated increased knowledge, support, and commitment to systems of care over the course of the initiative. Interagency collaborative members awarded strong ratings for capacity building variables (e.g., shared vision and cohesion, leadership, communication) in their communities. Further, community partners perceived their efforts as increasingly effective in promoting positive changes in policies, procedures, and practices and creating positive outcomes for children and families.

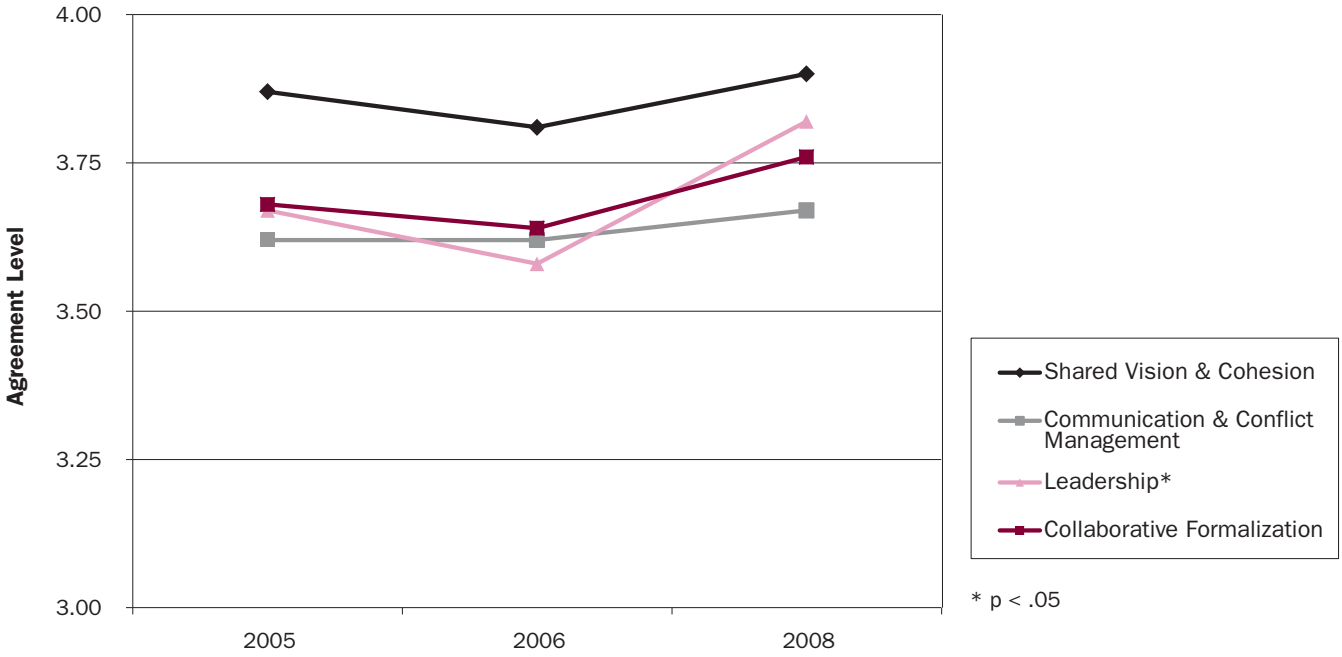
Community collaboratives served as vehicles for increasing interagency collaboration.

For the majority of grant communities, establishing a new collaborative or incorporating Systems of Care efforts into an existing collaborative were effective means to engage a vast array of stakeholders, including child- and family-serving agencies, community organizations, nonprofits, community residents, and family members, in planning efforts. By reducing fragmentation and duplication of resources and services, and better coordinating service provision for vulnerable families, systems of care provided a framework for these diverse stakeholders to work together to meet the needs of children and families.

In many cases, the Systems of Care demonstration initiative represented the first time that child welfare was leading interagency efforts. The grant program provided an unprecedented opportunity for child welfare to educate partner agencies about the varied services and supports it provides to vulnerable children and families and to dispel some negative preconceptions. Qualitative findings also suggested that the integration of family and community members as partners in these governance structures helped to alter the child welfare agency's relationship with the community by enhancing public perceptions of the child welfare system. As a result, stakeholders credited the initiative with raising the profile of the agency and garnering community support.

Data from collaborative member surveys indicated that systems of care collaborative groups often followed an uneven, but typical, developmental process. That is, ratings in capacity building variables—such as shared vision and cohesion, communication, conflict management, and leadership—often rose and fell as stakeholders got to know the initiative and one another, began to develop relationships, encountered barriers or conflicts, and then resumed development of trust in the work of the collaborative. By the end of the grant period, the formalization and cohesion of the collaborative increased, leadership roles peaked, and conflict among stakeholders decreased (see Graph 1). These findings provided a positive indication of the grant communities' ability to sustain their interagency

Graph 1: Collaborative Development and Capacity Building Across Grant Communities[10]



collaborative structures. Evidence from the qualitative studies confirmed both the strength and sustainability of these collaborative structures.

3.2 Organizational Change

For the purposes of the evaluation, organizational change was defined as changes in policies, practices, and procedures within child welfare agencies. Analysis of organizational change addressed the extent to which communities integrated the six systems of care principles into child welfare processes and structures. Grant communities implemented a wide range of activities and initiatives to address each of the six principles (see Figure 2).[11]

Integration of the systems of care guiding principles in policies, practices, and procedures was central to organizational change.

Complementary changes at systems and practice levels are needed for sustainable impact on child welfare outcomes. Principles were implemented both at the systems level and the direct service level. For example, in the case of family involvement, child welfare agencies worked to involve family members in planning and implementing Systems of Care, while also employing Family Group Decision-Making meetings and other family-centered practices at the case level. Similarly, interagency collaboration and community-based approaches were enhanced at the systems level through the development and activities of interagency collaborative bodies, and at the practice level through collective input into case plans and strengthening connections to community services. Strengths-based and culturally relevant approaches were integrated into staff training and increasingly adopted in caseworker interactions with families. Accountability was enhanced through local evaluation efforts and management

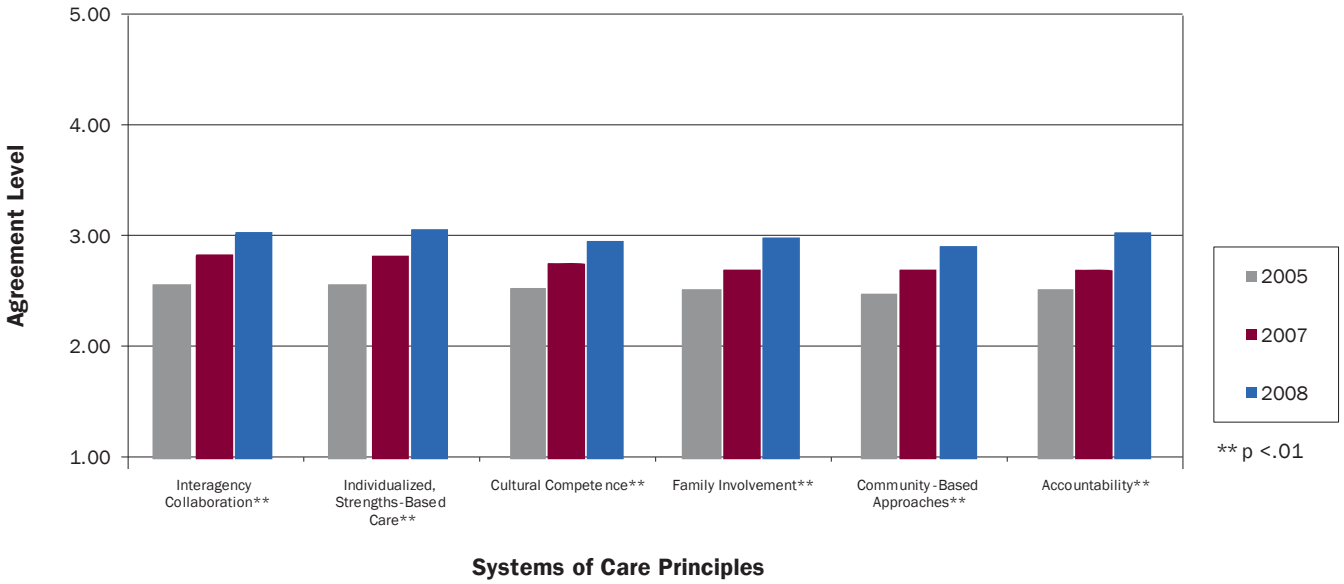
10 Data source: Systems of Care Collaborative Survey. A five-point Likert scale was used to rate respondents' agreement level from (1) strongly disagree to (5) strongly agree on a series of statements reflecting collaborative development variables.

11 For more information on each principle and additional examples of grant community activities related to the principles, see *A Closer Look* series, available at www.childwelfare.gov/management/reform/soc/communicate/initiative/closerlook/.

Figure 2: Overview of Systems of Care Principles

Interagency Collaboration	Individualized, Strengths-Based Care	Cultural Competence	Family Involvement	Community-based Approaches	Accountability
Agencies and organizations providing services to children and families work together to plan, develop, and coordinate care.	Policies and practices identify and draw on the strengths of children, family, and the local community, and acknowledge each child and family's unique set of assets.	Policies, practices, and services are responsive to the cultural, ethnic, linguistic, and racial diversity of children, families, and their communities.	Families and youth are partners in developing their own case plans and are participants in the planning and implementation of systems change activities.	Services and supports are community-based and comprehensive to address holistically child and family needs.	Data are used to evaluate the impact of agency policies and procedures, assess the effectiveness and quality of services, and inform decision-making.
Examples: • Multiagency, collaborative governance bodies • Interagency participation in case planning and team decision-making meetings • Cross-agency memorandum of understanding • Cross-training and interagency information sharing	*Examples:* • Strengths-based family assessment procedures and tools • Strengths-based and tailored case planning • Supervisory modeling of strengths-based approach • Training for child welfare and partner agency staff	*Examples:* • Organizational assessments to identify cultural competency issues • Staff training on culturally competent approaches to working with families • Community forums on disproportional representation in the child welfare system • Resources for staff to work with families from diverse cultures • Evaluation tools that reflect values and traditions of tribal communities	*Examples:* • Family and youth participation in case planning conferences • Peer-to-peer mentoring • Membership of families on collaborative governance bodies • Family participation in the design of agency policies and procedures • Parent co-trainers for staff training	*Examples:* • Resource guides and training on community-based organizations and services • Community outreach, liaisons, and social marketing to engage community members and increase resources • Inclusion of community representatives and natural supports in case planning meetings • Family partners to help locate community services • Efforts to increase placements in home community	*Examples:* • Local evaluations of systems of care initiatives • Use of evaluation data in ongoing systems reform • Management information systems linked to case management processes • Strategic planning retreats

Graph 2: Agency Support for Systems of Care Principles Across Time[12]



information systems that informed cross-system coordination, child welfare administration, supervision, and case planning and documentation.

To institutionalize the principles, grant communities integrated the Systems of Care principles into policy manuals and procedures, sometimes with input from former child welfare-involved families. Communities provided training and developed automated systems to further support changes in practice consistent with new or revised policies. Memoranda of understanding among partner agencies and legal contracts with community providers also helped ensure application of the principles in the provision of supports and services to children and families.

Child welfare agencies' support for systems of care principles increased over time.

Overall, as shown in Graph 2, data from child welfare staff surveys indicated statistically significant increases in child welfare agency support for each of the systems of care principles over the course of the initiative. During focus group discussions, staff also confirmed that they felt encouraged and supported to adopt principle-guided practices—working in partnership with other agencies and families in case planning activities, tailoring services to families' unique needs and cultural values, identifying placements and services within a child's community, and maintaining records needed for accountability.

While implementation of the guiding principles was focused primarily within the child welfare agencies, qualitative data suggested that, in some communities, interagency activities resulted in increased support of the principles within other child- and family-serving agencies as well.

Analysis of qualitative and quantitative data revealed variability across and within grant communities in their implementation of the principles. Communities often focused more resources and attention on selected principles, most frequently family involvement, or only addressed a single aspect of a principle (e.g.,

12 Data source: Systems of Care Child Welfare Agency Survey. Respondents answered questions related to their agencies' support for each systems of care principle; i.e., did they encourage, provide resources and infrastructure, and reward staff for implementation of the principle. Respondents used a five-point Likert scale to rate to what extent they agreed with statements related to agency support of principles: from (1) not at all to (5) to a very great extent. For more information, see *Systems and Organizational Change Resulting from the Implementation of Systems of Care*, available at http://www.childwelfare.gov/management/reform/soc/communicate/initiative/ntaec.cfm.

introductory cultural competency training or local evaluations as a mechanism for accountability). While overall progress was made in advancing the implementation of each principle, on average, the data suggested only moderate implementation levels were achieved. These findings are consistent with evaluations of other systems of care initiatives (Manteuffel, Stephens, Brashears, Krivelyova, & Fisher, 2008).

Family involvement at the case, peer, and systems levels resulted in transformative changes within child welfare and partner agencies.

Across grant communities, systems of care stakeholders reported galvanizing effects of involving families in their systems change efforts. Most grant communities made significant progress in changing case work practice and child welfare agency culture to embrace family involvement.

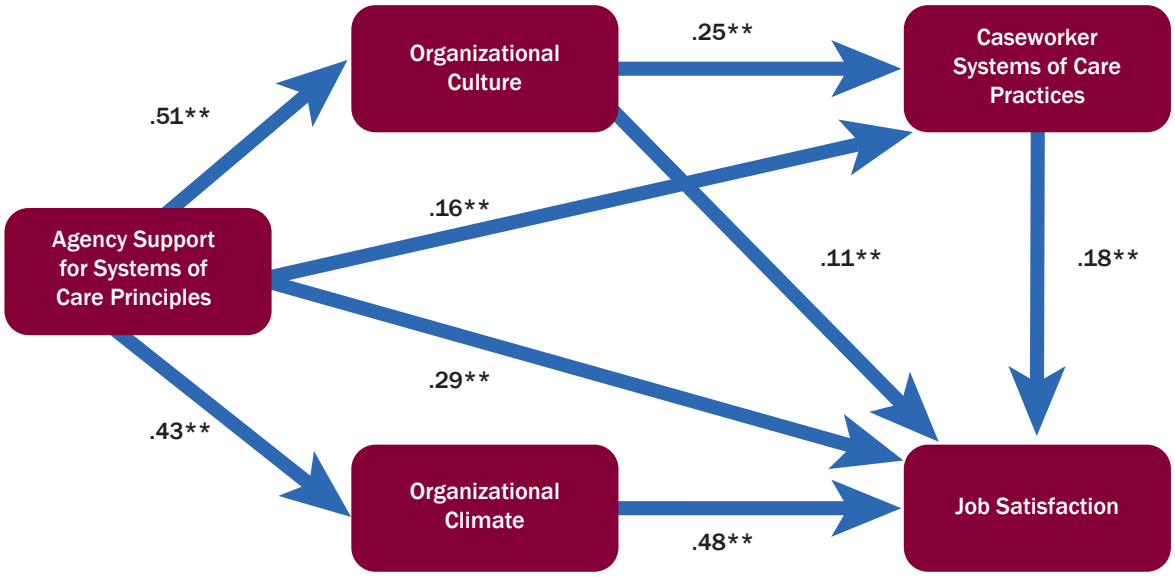
- At the case level, grant communities enhanced family involvement by implementing or expanding their family teaming approaches to be more consistent with the values and principles of systems of care. Case workers began actively engaging families and their support systems to play more active roles in development and execution of their case plans. Communities also established common definitions, policies, procedures, training, and quality assurance systems to support family teaming.
- At the peer level, communities implemented peer support program models in which families previously involved with the child welfare system helped current families to navigate the system.
- At the systems level, communities provided groundbreaking opportunities and support for families to serve on decision-making bodies (e.g., Systems of Care collaboratives and committees) and contribute to the design and improvement of agency policies and practices. Family members were actively involved in conducting trainings for child welfare and partner agency staff, providing an important and previously unheard perspective. They also participated in Systems of Care social marketing, provided input on client forms and resource materials, and participated in evaluation activities.

Grant communities tailored their family involvement activities to their target population, including not only birth parents, but also foster parents, kin-caregivers, and youth in foster care.

Evidence from the Systems of Care qualitative studies,[13] supported by local evaluation findings (Anthony, Berrick, Cohen, & Wilder, 2009; Denby, 2009; Lawrence & Snyder, 2009) demonstrate the significant benefits of family involvement activities. Respectful engagement of family members and their peers in decision-making and planning helped families recognize their own needs, strengths, and available resources and become more invested in case plans. Families felt supported, informed, and empowered to make necessary changes. Grant communities not only strengthened families' roles in informing the development of their own case plans but also helped family members develop the leadership skills and capacities necessary to support and advocate for their peers. Peer mentoring, in turn, led to greater family awareness of resources and options, and in some communities resulted in documented improvements in safety and permanency of children. In addition, family members in many communities collaborated for the first time with decision-makers, contributing their perspectives to inform the design and development of policies and programs. Ultimately, the implementation of a system of care approach provided a framework for grant communities to engage families in developing solutions, thereby transforming the relationship between child welfare staff and families involved with the system.

13 See *Family Involvement in the Improving Child Welfare Outcomes through Systems of Care and Systems of Care Case Studies*, available at http://www.childwelfare.gov/management/reform/soc/communicate/initiative/ntaec.cfm.

Figure 3: Systems of Care Organizational Change Model



**p< .01

While considerable strides were made, grant communities reported that increasing and sustaining family involvement was difficult and time consuming. A number of challenges were identified, most notably, a lack of structure and capacity of child welfare agencies to support family involvement, reluctance of child welfare staff to embrace the concept of establishing true partnerships with families, and the need to provide additional supports to family members to partner successfully. Among the strategies used by communities to overcome challenges and build capacity for family involvement were establishing dedicated full-time staff to coordinate family involvement activities, offering training to child welfare staff and family members, developing clear standards related to the requirements and supervision of peer mentors, and creating feedback mechanisms for continued monitoring and program improvement.

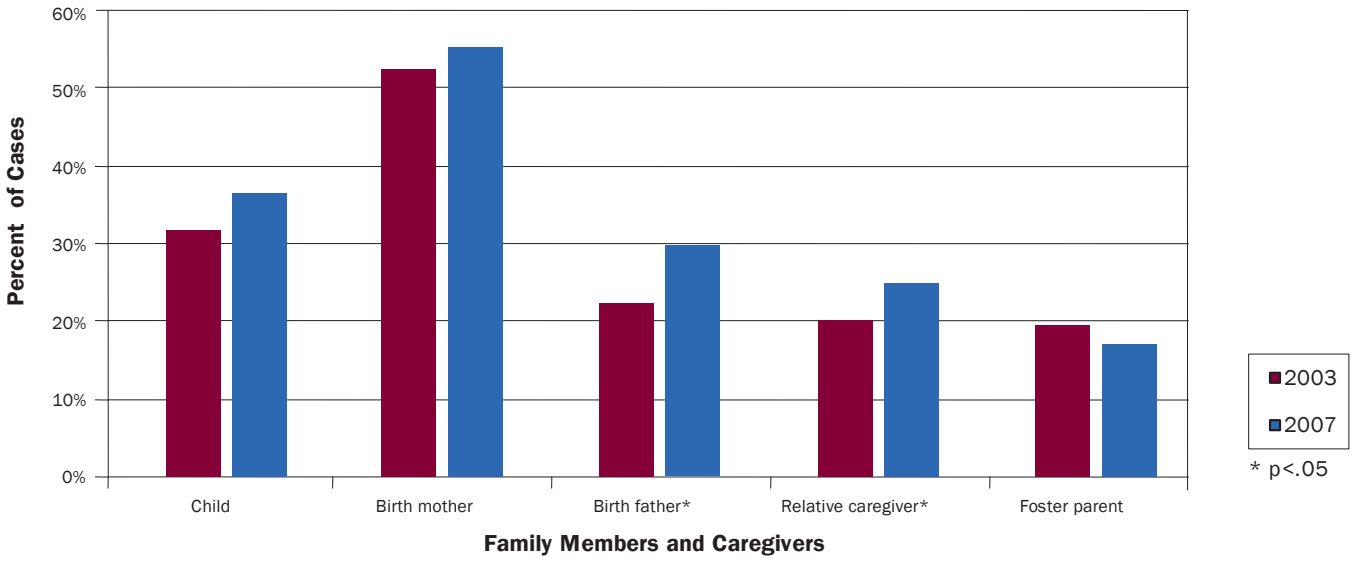
Agencies' support for systems of care principles was associated with improved job satisfaction.

Over the course of the initiative, caseworkers reported moderate improvements in job satisfaction. Survey results among caseworkers showed statistically significant increases from a mean of 4.49 in 2006 to 4.99 in 2008 on a scale of 1 (very unsatisfied) to 7 (very satisfied).

Analyses revealed that job satisfaction was affected both directly by agency support for systems of care principles and indirectly through the changes in organizational climate and culture. As caseworkers were encouraged to implement strengths-based, culturally responsive, and family-centered approaches to child welfare practice, they perceived a more positive organizational climate—one where agency rules and regulations increasingly promoted effective service provision and roles were more clearly defined. Caseworkers also experienced a more positive organizational culture in which they felt more supported and motivated in their day-to-day environment. Figure 3 summarizes the relationships between the key variables as demonstrated through structural equation modeling.[14] These findings suggest that the implementation of a system of care approach

14 The structural equation modeling analysis of how systems of care principles could affect organizational variables and job satisfaction was cross-sectional and only provided an assessment of agencies at one point in time.

Graph 3: Family Involvement in Case Planning



can potentially contribute to reduced turnover among caseworkers who feel better supported and more satisfied in their jobs.

3.3 Child Welfare Practices

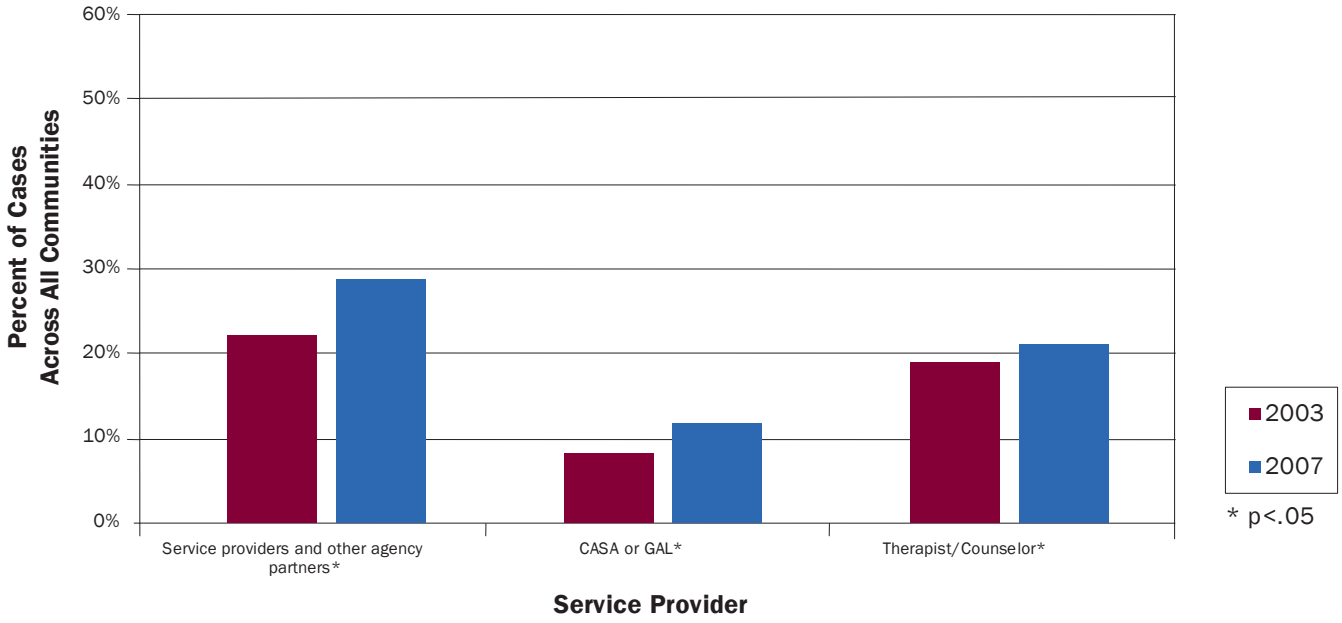
The conceptual framework theorized that systems and organizational change in Systems of Care communities would lead to positive changes in case planning and child welfare services. **Implementation of Systems of Care led to greater participation among partner agencies and family members in case planning and service provision**.

To improve case-level outcomes, Systems of Care emphasized the importance of a holistic case planning model that involved service providers, family members, community members, and other family support systems. As underscored in quantitative and qualitative data collection, grant sites spent significant time and effort on increasing collaboration and family and community involvement at the practice level through Family Group Decision-Making and similar family involvement approaches.

Analysis of case file data indicated that a greater number of family members and interagency partners became active participants in child welfare case planning processes and meetings (see Graphs 3 and 4.). In particular, notable and statistically significant increases were evident in involvement[15] of birth fathers (increasing from 22% to 30% of cases), relative caregivers (increasing from 20% to 25% of cases), and service providers and other agency partners (increasing from 22% to 29% of cases). In addition, family member and caregiver participation in services generally increased over the course of Systems of Care implementation. Increases were statistically significant only for participation by relative caregivers (14% to 21% of cases).

15 In the case file reviews, people and organizations were recorded as "involved" if there was evidence that they played a role in case planning activities during the review period. These included family members, caregivers, and partners who were involved in the assessment process, identified as a strength in the assessment process, identified by the child welfare agency as being able to address a need identified in the assessment process, consulted in the case planning process, or invited and participated in case planning activities (e.g., Family Group Decision-Making meetings).

Graph 4: Interagency Partners Involvement in Case Planning



Case file reviews also indicated positive trends in service provision by interagency partners. There were sizable and statistically significant increases in services by service providers and other partners (from 9% to 24% of cases), therapists and counselors (from 6% to 17% of cases), and court-appointed special advocates (CASA) or guardian ad litem (from 2% to 6% of cases).

These findings, supported by additional evidence from qualitative studies, confirm the systems-level finding of increased interagency collaboration and are consistent with the systems of care principles of interagency collaboration and family involvement.

4. Child Welfare Outcomes

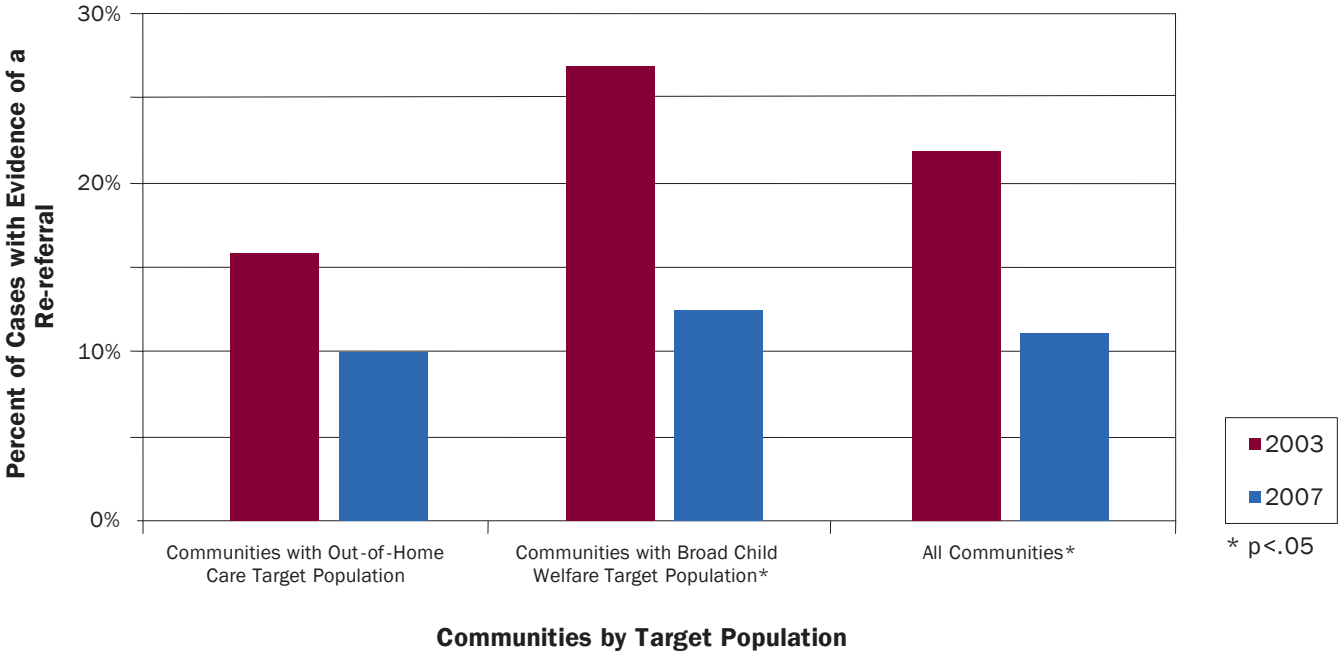
Reviews of randomly selected child welfare case files pointed to evidence of improved child safety, permanency, and well-being. Given the long-term nature of child welfare outcomes resulting from systems and organizational change, and the number of variables external to the Systems of Care initiative, causality cannot be definitively established for changes observed in safety, permanency, and well-being.

Systems of Care communities experienced improvements in child safety, as shown by a significant reduction in re-referrals into the child welfare system.

Reviews of randomly selected child welfare case files pointed to evidence of improved child safety. As shown in Graph 5, re-referrals to the child welfare agency across communities declined from 22 percent of cases in 2003 to 11 percent in 2007. Separate analyses addressed re-referrals in grant communities that targeted children in out-of-home care, a higher risk population, and those in communities that worked with a broader child welfare population. Evidence of a re-referral declined for both children from the out-of-home care target population (from 16% to 10%) and children in the broader target population (from 26% to 12%), but such a decline was statistically significant only among the latter.[16]

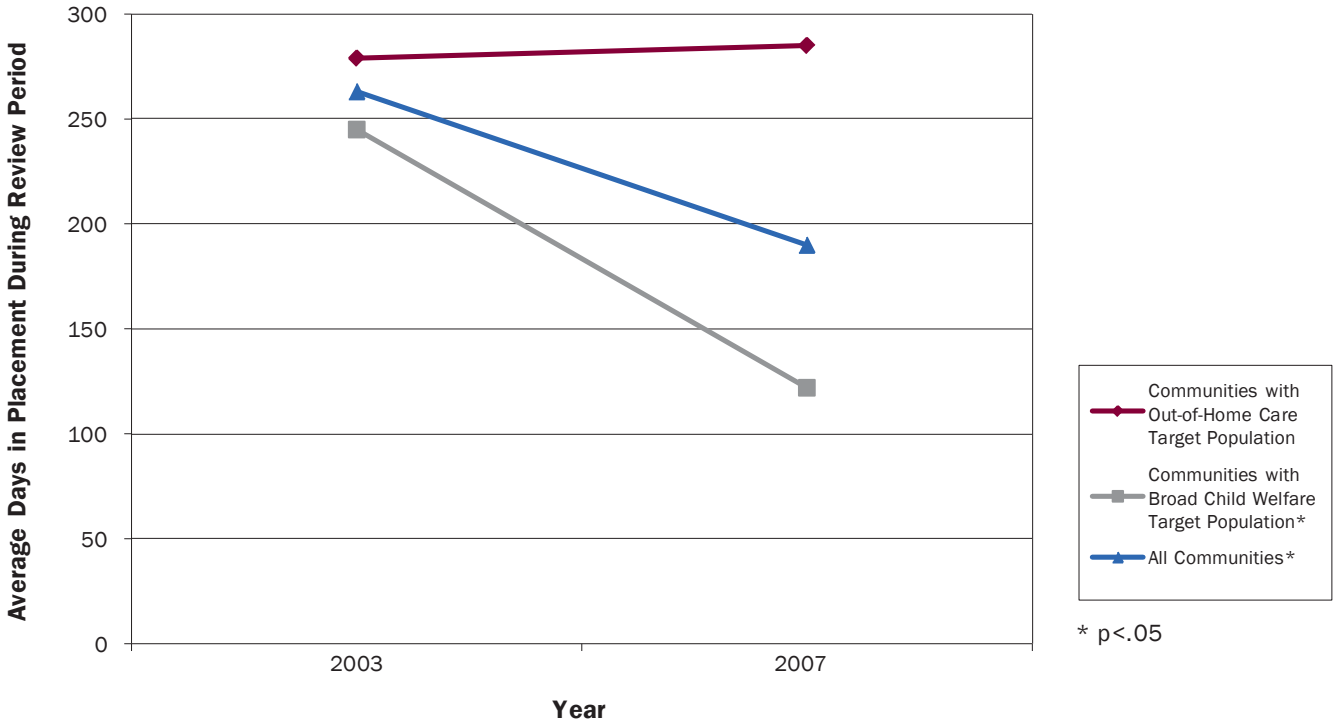
In addition, substantiation of re-referrals declined significantly from 9 percent to 5 percent across communities. There was a significant decrease in the substantiation of re-referrals in grant communities with broader target populations (dropping from 13% to 4%) and a slight, but not significant, increase in re-referrals in grant communities working only with children in out-of-home care (from 2% to 5%).

Graph 5: Re-referral to Child Welfare



16 The broader target population was much larger than the out-of-home care target population, making it easier to reach the significance threshold.

Graph 6: Average Days in Placement



Case file data revealed several positive permanency outcomes for children in Systems of Care communities.

The average number of total placements decreased from 1.6 to 1.2 across all communities. While communities that focused primarily on children in out-of-home care experienced no change in average number of placements, communities working with a broader child welfare target population (some of whom were placed in out-of-home care) experienced a statistically significant change in average number of placements from 1.4 to .08.

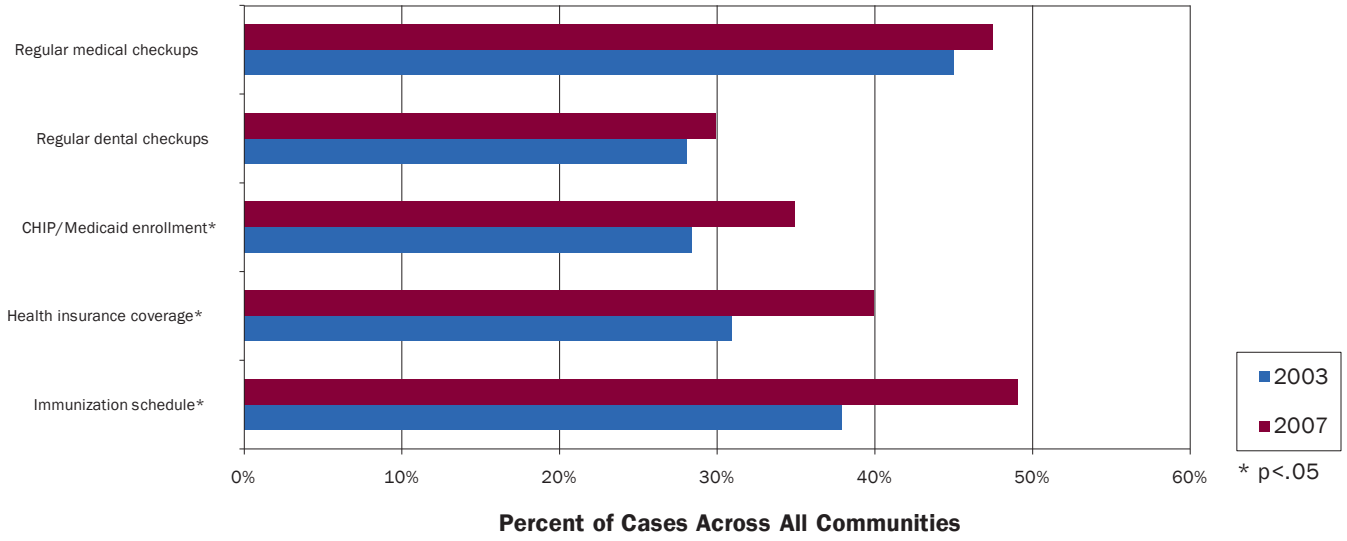
Total days in placement, across communities, declined 28 percent from an average of 263 days in 2003 to 190 days in 2007 (see Graph 6). While the average total days in placement increased slightly among communities that targeted only children in out-of-home care (279 days to 285 days), data revealed a significant increase in the time of the initial placement (from 192 days to 224 days) and decreased time in subsequent placements, suggesting improvements in placement stability for this high-risk group.

Additional analyses revealed that grant communities experienced other positive changes in placement type. For example, a greater number of children were placed with relative caregivers in Clark County, Nevada; more child adoptions took place in Oregon; and children experienced fewer foster care placements in Contra Costa, California.

The well-being of children participating in Systems of Care grant communities appeared to improve over the course of the initiative.

Case file reviews found improvements in child well-being indicators, including increases over the grant period in the percentage of children whose case files documented physical health assessments. As shown in Graph 7, case files also revealed increased documentation of medical checkups, dental checkups, Children's Health Insurance Program (CHIP)/Medicaid enrollment, health insurance coverage, and immunizations (the last three changes were statistically significant).

Graph 7: Child Physical Health Indicators



5. Lessons Learned and Conclusions

The national cross-site evaluation found that Systems of Care helped promote systems change by strengthening interagency collaboration and partnerships among the many organizations and individuals that influence the lives of children and families. Systems of Care also led to organizational changes within child welfare agencies, reflecting integration of systems of care principles in child welfare policies, procedures, and day-to-day practices, and resulting in greater participation of families and community partners in case planning and service provision. Ultimately, Systems of Care communities showed evidence of improvements in child welfare outcomes of safety, permanency, and well-being.

5.1 Lessons Learned in the Implementation of Systems of Care

The national evaluation findings indicated that there is no single template or recipe for systems of care and no single factor that guarantees success in implementing child welfare-led systems of care. Nonetheless, the evaluation revealed a number of lessons learned, which hold important implications for future systems change efforts.

1. Systems of care provide an overarching framework to coordinate and augment multiple systems and organizational change efforts within child welfare agencies.
2. The initiative's focus on infrastructure development rather than service delivery helped grant sites to connect and implement systems of care principles across all levels of the child welfare agency and into their policies, procedures, and practices as well as cross-system structures and processes.
3. An early focus on assessment and planning, coupled with intensive technical assistance, can enhance communities' readiness and capacity to implement systems of care.
4. Initiative leaders must recognize how to best leverage and integrate experience with other systems change and collaborative initiatives to align priorities and advance current goals.
5. Child welfare-led systems of care initiatives need strong and consistent leadership at the child welfare administrative level and project level.
6. Dedicated staff responsible for implementing specific principles or initiative components, as well as champions at all levels of the organization and community, are essential to garnering support and furthering successful integration of principles into policies and practices.
7. Succession plans and a shared vision can help minimize disruptions and keep initiatives on track during periods of leadership and staff turnover.
8. Stakeholder engagement and relationship building need to be proactive, inclusive, and ongoing.
9. Connecting the principles to tangible components that aid day-to-day practice can facilitate buy-in among frontline workers, who are a critical link between systems and organizational change and practice changes that lead to improved outcomes.
10. While challenging and time consuming, establishing family involvement at the case, peer, and systems levels can bring transformation within child welfare and partner agencies.
11. Promoting meaningful family involvement at all levels of the child welfare agency requires attention to necessary policy changes, training for child welfare agency staff and family members, requirements for peer mentor positions, clear definitions and procedures for family teaming, supervision, and feedback loops.

12. As a comprehensive approach, systems of care require ongoing and multi-faceted implementation of all six principles.
13. Involving local evaluators in a participatory action research approach throughout the course of the initiative and sharing data with stakeholders on an ongoing basis inform community decision-making, build stakeholder support, and strengthen accountability.
14. Embedding systems of care language and values into policies, procedures, training, and day-to-day practice is a powerful approach to sustain systems of care beyond the grant period.
15. Effecting systems and organizational change is a long-term process that requires ongoing commitment and investment.

5.2 Conclusions

Findings from the national cross-site evaluation of the Systems of Care initiative confirm the hypothesis that systems of care can result in systems and organizational changes that lead to improvements in child welfare outcomes. The experiences of the grant communities indicate that a principle-driven system of care approach has considerable potential for strengthening child welfare systems. Building from the demonstration's experiences, State, county, and tribal child welfare systems around the country can adapt systems of care to fit their local needs and unique characteristics. Guided by strong leaders, they can apply the values and principles of systems of care to unite the diverse perspectives of multiple child- and family-serving agencies, as well as community and family members, toward a shared vision for meeting the complex needs of children and families. Through sustained integration of the principles into policies and practices, child welfare agencies can continue to build greater capacity to deliver individualized, culturally competent, and coordinated community-based services, and promote positive child and family outcomes. Moreover, they will be able to align implementation of systems of care with the Child and Family Services Reviews process as well as other ongoing systems reform.

The national evaluation answered important questions regarding the efficacy of systems of care. However, the small sample size, limited time frame, and focus of the evaluation leave other questions unanswered:

- How do different approaches to infrastructure development and implementation of systems of care principles affect systems and organizational changes and child welfare outcomes?
- What impact do individual principles have on outcomes and what are the cumulative effects?
- How do organizational culture and climate and other agency factors and contextual variables interrelate to facilitate or impede systems and organizational change?
- What is the long-term impact on safety, permanency, and well-being of sustained systems of care implementation?

Additional research can further elucidate our understanding of child welfare-led systems of care.

As a demonstration initiative and the first cross-site evaluation of systems of care in a child welfare context, this "learning laboratory" is a valuable starting point. The resultant knowledge and lessons learned about what works in building infrastructure and implementing systems of care principles have broad implications and applicability for State, county, and tribal child welfare systems. Ultimately, dissemination of evaluation findings can contribute to cumulative learning, which will help guide and build the capacity of communities to undergo effective systems and organizational change, and as a result, enhance the safety, permanency, and well-being of children and families.

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National Technical Assistance and Evaluation Center Publications

A Closer Look

Title: *Family Involvement in Public Child Welfare Driven Systems of Care*
Published: 2008
Available: http://www.childwelfare.gov/pubs/acloserlook/familyinvolvement/

Title: *An Overview of Systems of Care in Child Welfare*
Published: 2009
Available: http://www.childwelfare.gov/pubs/acloserlook/overview/

Title: *Interagency Collaboration*
Published: 2008
Available: http://www.childwelfare.gov/pubs/acloserlook/interagency/

Title: *An Individualized, Strengths-Based Approach in Public Child Welfare Driven Systems of Care*
Published: 2008
Available: http://www.childwelfare.gov/pubs/acloserlook/strengthsbased/

Title: *Cultural Competency*
Published: 2009
Available: http://www.childwelfare.gov/pubs/acloserlook/culturalcompetency/

Title: *Community-based Resources: Keystone to the System of Care*
Published: 2009
Available: http://www.childwelfare.gov/pubs/acloserlook/community/

Title: *Accountability*
Published: 2010
Available: http://www.childwelfare.gov/pubs/acloserlook/accountability/

Children's Bureau Express

Title: *Family Organizations Promote Systems Change in Child Welfare* (Vol. 10, No. 1)
Published: February 2009
Available: http://cbexpress.acf.hhs.gov/index.cfm?event=website.viewArticles&issueid=102&sectionid=2&articleid=2516

Title: *Promoting Youth Involvement in a System of Care* (Vol. 10, No. 10)
Published: December 2009
Available: http://cbexpress.acf.hhs.gov/index.cfm?event=website.viewArticles&issueid=112&sectionid=2&articleid=2762

Evaluation Reports

Title: *Improving Child Welfare Outcomes through Systems of Care: Overview of the National Cross-Site Evaluation*

Title: *Systems and Organizational Change Resulting from the Implementation of Systems of Care*

Title: *Systems of Care Implementation Case Studies*

Title: *Family Involvement in the Improving Child Welfare Outcomes through Systems of Care Initiative*

Title: *Leadership in the Improving Child Welfare Outcomes through Systems of Care Initiative*
Published: 2010
Available: http://www.childwelfare.gov/management/reform/soc/communicate/initiative/ntaec.cfm

Strategic Planning/Infrastructure Development Resources

Title: *Improving Child Welfare Outcomes Through Systems of Care: Systems of Care: Guide for Strategic Planning*

Published: 2007

Available: http://library.childwelfare.gov/cwig/ws/library/docs/gateway/Record?rpp=10&upp=0&m=1&w=+NATIVE%28%27recno%3D56550%27%29&r=1

Title: *Improving Child Welfare Outcomes Through Systems of Care: Building the Infrastructure: A Guide for Communities*

Published: 2007

Available: http://library.childwelfare.gov/cwig/ws/library/docs/gateway/Record?rpp=10&upp=0&m=1&w=+NATIVE%28%27recno%3D60188%27%29&r=1

Title: *Systems of Care Infrastructure Toolkits*

- Strategic Planning
- Governance
- System Management
- Coordination of Services
- Communication
- Policy
- Finance
- Continuous Quality Improvement
- Training, Development, and Human Resources

Published: 2010

Available: http://www.childwelfare.gov/management/reform/soc/communicate/initiative/ntaec.cfm

Improving Child Welfare Outcomes through Systems of Care: Overview of the National Cross-Site Evaluation

Appendix A—Appendix B

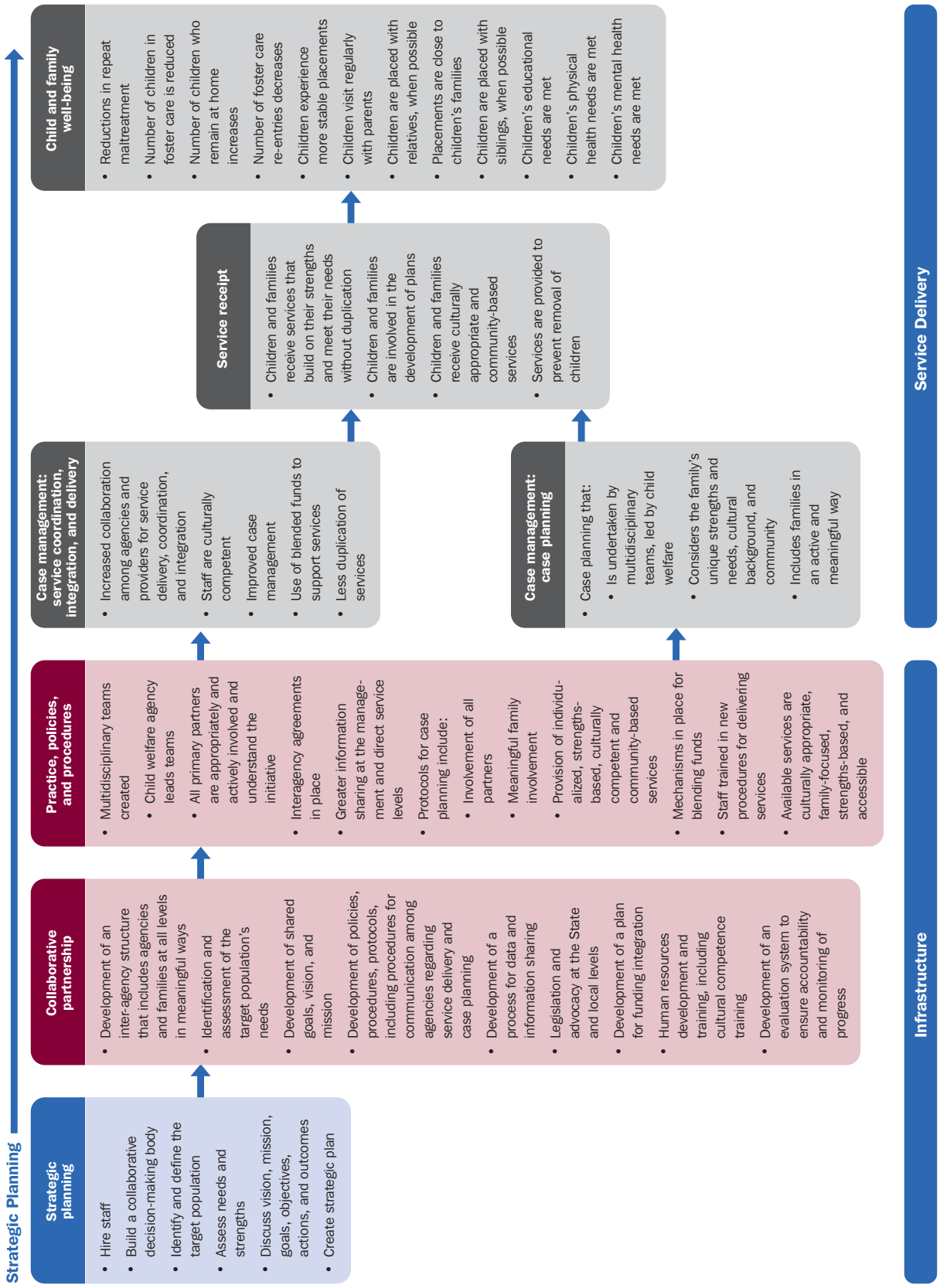
Appendix A: Systems of Care Conceptual Framework

Appendix B: Systems of Care Grant Communities

Appendix A:

Systems of Care Conceptual Framework

Systems of Care Conceptual Framework



Appendix B:

Children's Bureau Systems of Care Grant Communities

Children's Bureau Systems of Care Grant Communities

Grant Community	*Initiative Name*	*Target Populations*	*Key Focus Area*	*Prior Systems of Care Experience*
California Contra Costa County	Family-to-Family System of Care	Children and families entering emergency shelter care who were at risk for repeated placement failure Transitional age youth not participating in Independent Living Skills Programs Youth jointly supervised by Child and Family Services, Juvenile Probation, or Children's Mental Health	Expanded Family-to-Family services to address needs of target population; developed Parent Partner Program to support birth parents; and developed consumer-driven Team Decision-Making approach for youth.	A Casey Family-to-Family site Substance Abuse and Mental Health Services Administration (SAMHSA) Systems of Care Grant Initiative began with a very strong System of Care Policy and Planning Council
Colorado Jefferson County	Improving Child Welfare Outcomes through Systems of Care	Children, youth, and families involved in the child welfare system	Developed case flow management, data, and information systems improvements to case practice; utilized geo-mapping to assess needs and resources; and developed cross-systems training to integrate the systems of care principles into other child- and family-serving systems.	Federation of Families for Children's Mental Health Initiative A Casey Family-to-Family site

Grant Community	*Initiative Name*	*Target Populations*	*Key Focus Area*	*Prior Systems of Care Experience*
Kansas Cherokee County Reno County	Developing Family-Based Systems of Care for Local Communities in Kansas	Children and youth at risk of entering or involved in the child welfare or juvenile justice systems	Focused on infrastructure development related to family involvement. Supported the development of a Family Advisory Network to facilitate family involvement in child welfare and promote collaboration and partnerships among all relevant stakeholders.	SAMHSA Systems of Care Grant
Nevada Clark County	Caring Communities Demonstration Project	Children involved with the child welfare system and the kin caregivers with whom they reside	Focused its efforts on developing and implementing a Kin Care Liaison Program to support kin caregivers within child welfare.	SAMHSA Systems of Care Grant
New York Bedford-Stuyvesant Community Borough of Brooklyn New York City	The CRADLE in Bedford Stuyvesant: A System of Care Initiative	Families who have children ages birth to 1 year old, with a primary focus on families who are either the subject of a substantiated maltreatment report, whose children have already been placed in foster care, or both	Employed a community organizing/ empowerment approach to increase the coordination of services and the implementation and integration of systems of care into child welfare practice.	None

Grant Community	*Initiative Name*	*Target Populations*	*Key Focus Area*	*Prior Systems of Care Experience*
North Carolina Alamance County Bladen County Mecklenburg County	Improving Child Welfare Outcomes Through Systems of Care	Children who are victims of, or are at risk for, child abuse and neglect	Developed tools, protocols, and procedures to facilitate the implementation of the systems of care principles into child welfare agency policies, practices, and procedures. Developed training curricula related to the implementation of Child and Family Team meetings within child- and family-serving agencies.	SAMHSA Systems of Care Grant
North Dakota Three Affiliated Turtle Mountain Spirit Lake Standing Rock	The Medicine Moon Initiative to Improve Tribal Child Welfare Outcomes Through Systems of Care	Native American children and families who are involved with tribal and State child welfare agencies	Utilized the Systems of Care initiative to support infrastructure development within the four tribal agencies, including culturally appropriate processes and case management data collection practices.	Project director served as the project director of a SAMHSA Systems of Care Grant
Oregon Clackamas County Washington County Umatilla-Morrow County	Improving Permanency Outcomes Project	Children who have been in out-of-home care for longer than 8 months with a reunification case plan Children in out-of-home care with alternative permanent planned living arrangement designations that do not include reunifications, adoptions, or guardianship	Utilized family involvement as a key strategy to achieve improved permanency outcomes.	Class action suit requiring the use of a system of care approach within child welfare

Grant Community	*Initiative Name*	*Target Populations*	*Key Focus Area*	*Prior Systems of Care Experience*
Pennsylvania Northumberland County Dauphin County	Locally Organized Systems of Care for Children in Pennsylvania	Children and adolescents, ages 6 to 18, who are involved in the child welfare system and at least one other child-serving system (e.g., mental health, mental retardation, drug and alcohol, education, and/or juvenile probation)	Developed several strategies to support cross-systems service integration and community engagement to achieve improved outcomes for children and families.	SAMHSA Systems of Care Grant

California Children's System of Care: Where have we been?

History of the Children's System of Care Movement

Pamela Hawkins,

United Advocates for Children of California

January 27, 2005

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National Children's System of Care

- 1983: CASSP funded by Congress; system of care values and principles initially articulated by Stroul and Friedman for CASSP
- 1986: State Comprehensive Mental Health Services Plan Act
- 1989: Robert Wood Johnson Foundation: Mental Health Services Program for Youth (MHSPY)
- 1992: Comprehensive Community Mental Health Services for Children and Their Families Program
- 1994: SAMHSA/CMHS Grants to California counties

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California Children's System of Care

- 1984: AB 3920 Ventura County Pilot Project
- 1988: AB 377 Expansion of the Ventura Model
- 1992: AB 3015 The Children's Mental Health Services Act
- 1996: AB 1667 Expansion of The Children's Mental Health Services Act
- 2000: SB 1452 Senator Cathie Wright refined legislation for Children's System of Care
- 2002: Interagency Enrollee Based Program

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CASSP

- The definition of a system of care for children with emotional disorders was first published in 1986:
  - *A comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and their families*
  - Comprehensive, incorporating a broad array of services and supports
  - Individualized
  - Provided in the least restrictive appropriate setting
  - Coordinated both at the system and service delivery levels
  - Involve families and youth as full partners
  - Emphasize early identification and intervention

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California Counties funded by SAMHSA/CMHS CSOC Grants

- February 1994: (California 5) Riverside, San Mateo, Santa Cruz, Ventura, and Solano Counties
- October 1994: Napa, Sonoma, Placer and Santa Barbara Counties
- October 1997: San Diego County
- October 1999: Contra Costa County
- October 2002: Glenn, San Francisco, and Sacramento Counties
- February 2003: Monterey County
- Humboldt and Del Norte Counties: Wraparound System of Care
- United Indian Health Services, Inc: Arcata, California

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Ventura Model

- Major reform in the delivery of mental health services for children in California
- Core Values and Guiding Principles
- Interagency Collaboration
- Individualized Services
- Community Based Services
- Outcome Evaluation

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Family Partnership

- New roles for family members and professionals
- Family involvement at all levels
  - Policy
  - Management
  - Direct Service
- Family programs
  - Support
  - Education
  - Advocacy

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Cultural Competency

- Creating a culturally and linguistically competent system of care
  - All levels of the system: Administration, Management, Personnel, Agencies
- Cultural competence as an intrinsic element of every system of care function
  - California Implementation of the Cultural Competency Model
- Building a structure that addresses cultural competence issues within a system of care
  - Leadership
  - Self-assessment
  - Involvement of diverse persons in an advisory capacity

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SB 1452: Expansion of Children's System of Care

- Family partnerships strengthened
- Children ages 0-5 and transition age youth included as part of the CSOC target population
- Greater interagency collaboration and planning requirements
- Required performance outcome measures expanded upon
- State Department of Mental Health oversight strengthened

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Interagency Enrollee-Based Program

- Governor Davis directive to DMH to report on CSOC outcome data
- Changes in CSOC method of evaluation
- Development of new evaluation methods that target individual CSOC client outcomes
- Methodology
- Data Reporting
- Findings

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Responding to the Changing Needs of Children and their Families

- The Research and Training Center for Children's Mental Health: Transformation Survey (2004)
  - Increased emphasis should be placed on prevention and early intervention
  - Expanding the population
  - Increased family participation
  - Greater collaboration
  - Emphasis on transforming mental health treatment
  - Information dissemination of CSOC principles to the public, families, mental health professionals and pre-professionals

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California Children's System of Care: What do we know?

CSOC OUTCOMES

Chuck Anders M.A.
United Advocates for Children of California
January 27, 2005

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Overview

- The Bickman Studies
  - Fort Bragg
  - Stark County
- The California Studies
  - Rosenblatt Statewide Evaluation
  - Santa Barbara MISC
- The MACRO National Studies
  - CMHS National CSOC Evaluation
  - Longitudinal Child and Family Outcome Study

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Fort Bragg Study

- Youth in the experimental group received more services.
- Cost per youth served was higher in the experimental group.
- Youth in the both the experimental and control group improved.
- No significant difference between the experimental and comparison group.

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Stark County Study

- Youth in the system of care were more likely to receive case management services at 6 and 12 months.

- Youth in the system of care were more likely to receive home visits at 6 months.

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Stark County Study

- All youth improved in almost all outcome measures.
- Youth treated in the system of care had a lower externalizing behavior score on the YSR at 24 months.
- No other significant differences.

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California Statewide Evaluation

- Earlier funded counties tended to show more consistent cost savings.
- Students enrolled in education/mental health programs tended to show improvement academically.

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California Statewide Evaluation

- A reduction in the number of charges filed and charges sustained compared to the year prior to program admission.
- Rates of recidivism for non-probation related violations in the year subsequent to program admission varied from county to county.

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California Statewide Evaluation

- A number of youth experienced clinical improvement on the CBCL
  - AB377/CMHS – 42.9%
  - AB3015 – 34.8%
  - AB1667 – 43%
  - All Counties – 40.7%

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California Statewide Evaluation

- A number of youth experienced functional improvement on the CAFAS
  - AB377/CMHS – 39.7%
  - AB3015 – 35.2%
  - AB1667 – 37.6%
  - All Counties – 37.9%

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Santa Barbara MISC Study

- A number of youth experienced significant improvement on the CBCL
  - CBCL Externalizing Scale
    - Troubling Cluster
  - CBCL Internalizing Scale
    - Troubled Cluster and Troubled and Troubling Cluster
  - CBCL Total Problem Scale
    - Troubling Cluster and Troubled and Troubling Cluster

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Santa Barbara MISC Study

- A number of youth experienced significant improvement on the CAFAS Total Score.
  - Troubling Cluster
  - Troubled and Troubling Cluster

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CMHS National CSOC Evaluation

- Statistically significant decrease in total CAFAS score from intake to 6 months and 1 year.
- A number of youth showed clinically significant improvement on the CBCL at 6-months (28%) and 1 year (37%)
- A number of youth showed clinically significant improvement on the YSR at 6-months (29%) and 1 year (39%).

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CMHS National CSOC Evaluation

- A significant increase in the number of children who attended school more than 50% of the time at 6 months and 1 year.
- Overall, children's school performance improved from intake to 6 months and 1 year.

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CMHS National CSOC Evaluation

- Decline in the number of youth who had contact with the juvenile justice system
  - Year Prior to Intake – 26%
  - First Six Months – 20%
  - Second Six Months – 19.5%

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CMHS National CSOC Evaluation

- The percentage of children who had lived in multiple living arrangement declined from intake to 6 months and 1 year.
  - Intake 42%
  - 6-months – 27.1%
  - 1 year – 24.8%

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Longitudinal Child and Family Outcome Study

- System of Care Practice Review Study (SOCPR)
  - Three CMHS funded CSOC sites (Stark County, Santa Cruz County and East Baltimore)
  - Three matched comparison sites (Mahoning County, Austin, and West Baltimore)
- Risk of Juvenile Justice Study
  - Stark County and Mahoning County

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SOCPR Study

- CMHS funded CSOC sites scored significantly higher on the SOCPR.
- Youth in the CSOC sites scored significantly lower on CBCL at 12 month follow up.
- No difference on CAFAS at 12 months.

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SOCPR Study

- CBCL total problem score significantly negatively correlated with the SOCPR for comparison sites only.
- CAFAS total score significantly negatively correlated with SOCPR score at 12-months for the comparison group only.

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Juvenile Justice Study

- Risk of initial juvenile justice involvement decreased marginally in Stark County when compared to Mahoning County.
- Risk of initially committing a serious crime decreased significantly in Stark County when compared to Mahoning County.

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Juvenile Justice Study

- Risk of juvenile justice recidivism was marginally reduced in Stark County when compared to Mahoning County.
- Risk of juvenile justice recidivism due to serious offenses was significantly reduced in Stark County when compared to Mahoning County.

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California Children's System of Care: What have we learned?

Bill Carter LCSW

California Institute for Mental Health

January 27, 2005

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California Children's System of Care: What have we learned?

- CSOC Implementation varied greatly
  - Big C and Little c SOC
- Can CSOC be delivered with Fidelity?
  - Variable model definition
  - Is the sufficient accountability (personal, county/agency, state)
  - Can it (was it?) be measured, and used to guide decision making

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California Children's System of Care: What have we learned?

- Were Components operationalized or measured?
  - What constitutes Interagency Collaboration?
  - What constitutes Cultural Competence?
  - What constitutes Family Partnership?
  - What Constitutes Continuum of Care?

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California Children's System of Care: What have we learned?

–Did CSOC demonstrate "accepted" or "credible" outcomes?

- Measuring "Client" and "System" outcomes in today's environment is complicated
- Savings and other outcomes could not be attributed CSOC given multiple initiatives
- Like AB 2034, CSOC was initially implemented in a simpler environment
- State and county outcome/evaluation systems varied, were not robust
- Little emphasis upon effective practices/services negatively impacted child/family outcomes

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December 22, 2004
Work Group Follow Up

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Initial Summary Findings

- CSOC must serve the broad population of children and families in need.
- The CSOC Planning Model should be "reintroduced" into CSOC.
- Increased attention to quality of services.
- Accountability, originally embodied in the Outcome and Evaluation CSOC component, should be a central theme in rearticulating the model.

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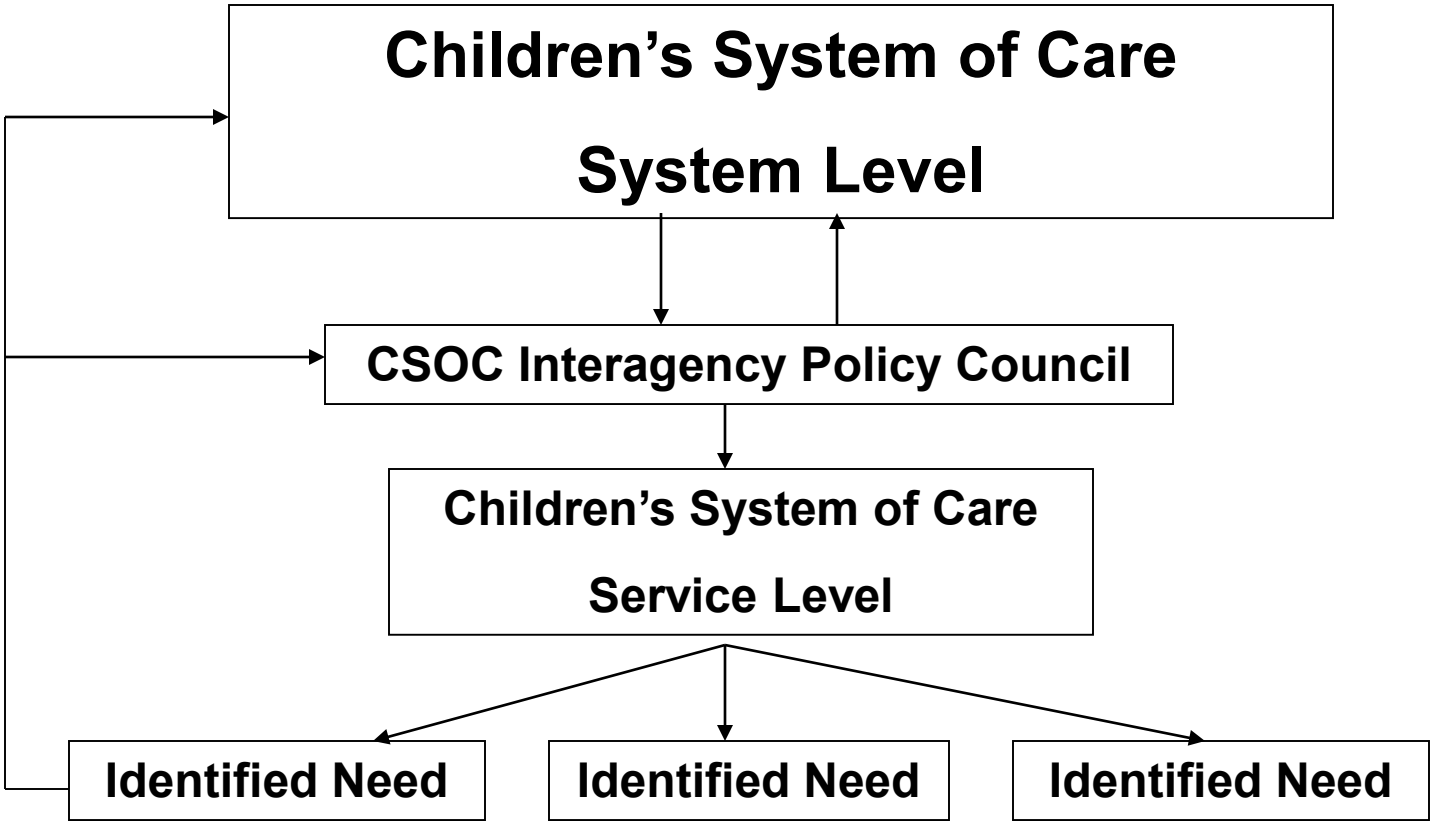
DRAFT CSOC Flow Chart



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CSOC - System Level

CHILDREN'S SYSTEM OF CARE – SYSTEM LEVEL

CSOC is an integrated system serving children & families with a range of needs.

A Children's Stakeholder Oversight Commission provides community input that guides the system to assure that the system and services reflect CSOC Values and Principles:

- Interagency Collaboration
- Family/ Youth Partnership
- Cultural Competence
- Community – Based Continuum of Care
- Individualized Care
- Outcome Evaluation

Potential Members of the commission include, but are not limited to, representatives from Public and Private Child and Family Service Agencies, Child and Family Advocacy Organizations, Law Enforcement, Courts, Health Care, Child Care, Business, Churches, County Supervisors, Foster Parents, Neighborhood Associations and others.

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CSOC - System Level

Promotes Community Participation in CSOC & CSOC Accountability to the Community

- Creates Forums for Community Discussion
- Creates Forums to Promote and Assess the System's adherence to CSOC Principles (Family Partnership, Cultural Competence, Interagency Collaboration, Outcome/Evaluation)
- Receives and reviews county, system and service data.
- Recommends System and Service Priorities

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CSOC - Interagency Policy Council

CSOC Interagency Policy Council

In response to Community Input, State and County responsibilities, and county data, builds and maintains an integrated Children's System of Care

Membership as defined in statute: Directors of Mental Health, Social Services, AOD Services, Chief Probation Officer, etc.

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CSOC - Interagency Policy Council

Responsible for CSOC Implementation

- Administers CSOC
- Provides data and report to the Children's Stakeholder Oversight Commission
- Receives recommendations from the CSOC Community Children's Stakeholder Oversight Commission
- Reviews Data, Identifies Needs to be addressed.
- Oversight and supervision of System and Services

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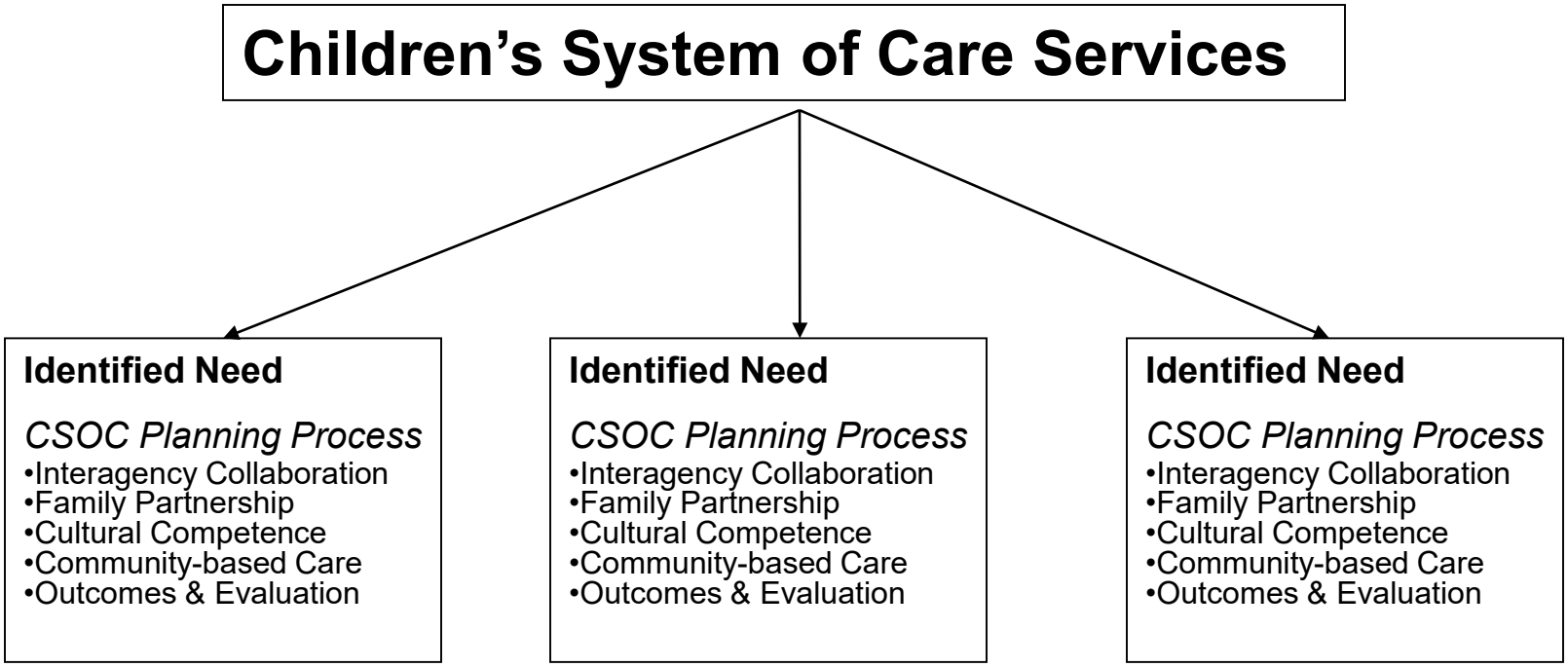
CSOC - Services



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CSOC - Services

- Identify a need
- Identify desired outcomes
- Describe activities that support Family Partnership
- Describe activities that reflect Cultural Competence
- Identify effective services
- Monitor fidelity
- Monitor Outcomes

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CSOC - Outcome Structure

- **Level I – Service Fidelity**
- **Level II – Foreground Outcomes**
- **Level III – Background Outcomes**

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CSOC - Outcome Structure

- Level I – Service Fidelity
  - Monitor the degree to which a child/family receives a service as it is designed.
  - Allows determination of whether or not outcomes result from service or poor delivery of service.
- Standardization
  - Standard for manualized &/or well developed practices.
  - Unique for non-manualized &/or standardized practices

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CSOC - Outcome Structure

- Level II – Foreground Outcomes
  - Measure short-term change.
  - Measures are shared by clusters of children & families & services that have common characteristics.
- Standardization – Three Options
  - State Standardization – Same measures for identified clusters
  - Counties voluntarily join consortia that utilize common measures for identified clusters
  - Unique between counties.

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CSOC - Outcome Structure

- Level III – Background Outcomes
  - Measures long term outcomes
  - Similar to earlier Performance Outcome Measurement Process
- Standardization – Three Options
  - State Standardization – Same measures for identified clusters
  - Counties voluntarily join consortia that utilize common background measures
  - Unique between counties.

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Work Group Questions & Comments

- General Response
  - Positives
  - Negatives
- Does it adequately address
  - “who is served in CSOC”?
  - how youth are being served in CSOC?
  - the quality of services?
  - accountability?
- What are the next steps in model development?

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CHCS Center for Health Care Strategies, Inc.

Making Medicaid Work for Children in Child Welfare: Examples from the Field

June 2013

Funded by: The Annie E. Casey Foundation

www.chcs.org

Making Medicaid Work for Children in Child Welfare: Examples from the Field

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The **Center for Health Care Strategies** (CHCS) is a nonprofit health policy resource center dedicated to improving health care access and quality. We work with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve low-income Americans, especially those with complex and high-cost health care needs.

For more information, visit www.chcs.org.

Contents

"Safety and permanency are necessary but not sufficient to ensure well-being."

Bryan Samuels, Commissioner, Administration for Children and Families
U.S. Department of Health and Human Services

Medicaid Strategies Important to the Child Welfare Population

Background

Nearly all children involved with the child welfare system are eligible for Medicaid, which is the primary source of funding for both physical and behavioral health care for this population. The extent to which the Medicaid benefit structure and service delivery system are customized for children in child welfare has a critical bearing on whether states can meet the mandated child welfare goals of safety, permanency, and especially, social and emotional well-being.

It is well documented that children in child welfare have significant health care needs, including physical, dental, and behavioral health needs. Nationally, their expenditures in Medicaid are driven more by behavioral health care use than by physical health care use, suggesting the critical importance of effective Medicaid delivery systems for both physical and behavioral health care.[1]

Some states have undertaken collaborative efforts across child welfare, Medicaid, and behavioral health systems to "make Medicaid work" more effectively for children involved with child welfare and their families and caregivers. Their experiences can inform other states about effective Medicaid strategies and how to approach the necessary systemic changes.

The Annie E. Casey Foundation commissioned the Center for Health Care Strategies to explore strategies used in selected states to improve Medicaid for children in child welfare. The project involved reviewing state child welfare, Medicaid, and behavioral health system background materials and developing an interview protocol to collect information about a range of strategies affecting the Medicaid program. Four states that have made progress were selected, and key individuals were identified in each state to interview by phone. Five or more individuals were interviewed in each state, at minimum including representatives from the child welfare, Medicaid, and behavioral health systems. Information from each state was synthesized to develop case studies that detail their strategies and accomplishments. Information across states was also analyzed to derive general observations and lessons learned. This document discusses the Medicaid strategies that emerged as most important for effectively serving children in child welfare and then presents case studies highlighting the experiences of Arizona, Massachusetts, Michigan, and New Jersey. The document concludes with a discussion of cross-state observations and lessons learned.

Most Important Medicaid Strategies

The protocol used to guide the interviews with key informants in the four states studied explored Medicaid strategies in eight areas including: (1) Medicaid financing; (2) enrollment, eligibility, and access; (3) screening and early intervention; (4) covered services; (5) individualized service planning; (6) psychotropic medications; (7) Medicaid providers; and (8) performance and outcome measurement. Each of these areas is discussed briefly below, highlighting the strategies assessed to be most significant for meeting the needs of the child welfare population.

Medicaid Financing

- **Medicaid Match** – A strategy for some of the states is to use child welfare general revenue as Medicaid match to expand home- and community-based services. State dollars used for Medicaid services draw federal match dollars at a 50 percent or higher match rate, so use of child welfare general revenue for children in foster care, most of whom are Medicaid-eligible, and for Medicaid-eligible services makes more sense than spending 100 percent state-only dollars. In Arizona, for example, the child welfare system contributed funds to the Medicaid behavioral health system as Medicaid match, allowing the state to draw down additional federal Medicaid dollars to generate more resources for services. In Michigan, the child welfare system moved funds to the behavioral health system to provide Medicaid match. With the additional federal Medicaid dollars that are captured, increased resources are available to provide services to children in child welfare with serious emotional disturbances under the state's Medicaid 1915(c) Home and Community-Based Services Waiver.

  For behavioral health services in New Jersey, the state identified services previously supported solely with state dollars that could be incorporated into the state Medicaid plan, allowing the state to capture federal funding for these services. In the first year of its system reform, New Jersey financed its Medicaid match by combining existing state dollars being spent on children with serious emotional disturbances through child welfare

Key Medicaid Strategies for the Child Welfare Population

Medicaid Financing
- Use of child welfare general revenue as Medicaid match to expand home- and community-based services
- Risk-adjusted rates and incentive payments to guard against under-service and encourage evidence-informed practices

Eligibility, Enrollment, and Access
- Presumptive Medicaid eligibility for children in child welfare
- Coverage of children in foster care beyond age 18
- Co-location and Medicaid financing of health and behavioral health liaisons in child welfare offices to assist with eligibility, screening, access, linkage, consultation, and crisis intervention

Screening and Early Intervention
- Timeframes for physical, behavioral, and dental health screens through EPSDT for children entering care
- Use of standardized screening tools

Covered Services
- Robust Medicaid benefit covering home- and community-based services including such services as family peer support, mobile crisis response and stabilization services, therapeutic foster care, and intensive in-home services
- Coverage of evidence-based practices such as Trauma-Focused Cognitive Behavioral Therapy

Individualized Service Planning and Intensive Care Coordination
- Coverage of Wraparound practice model to support individualized care planning
- Coverage of intensive care coordination at low care coordinator to child ratios (e.g., 1:8-10) for children with complex needs

Psychotropic Medication
- Monitoring of psychotropic medication utilization and consultation to prescribers and child welfare workers

Medicaid Providers
- Inclusion of skilled child welfare providers and specialists in Medicaid networks
- Practice guidelines and protocols for Medicaid providers
- Ongoing training on the unique needs of the child welfare population and effective practices

Performance and Outcome Measurement
- Performance expectations specific to the child welfare population for Medicaid managed care entities and providers and monitoring of quality of implementation
- Tracking of performance, service utilization, expenditures, and outcomes specific to child welfare population
- Cross-agency data sharing agreements and use of data to identify areas needing improvement and to show results

and behavioral health (including funds previously expended on residential care) with new funds authorized in the state budget to build its statewide system of care.

- **Risk Adjusted Rates and Incentive Payments** – An important financing strategy for the child welfare population is to use risk-adjusted rates and incentive payments to provide sufficient resources to serve this high-need group and guard against under-service. In Arizona, a single Medicaid health plan was created to provide all medically necessary physical health and dental services to children in foster care. This plan is financed through a risk-adjusted capitation rate. Similarly, the behavioral health capitation rates paid to the state's regional behavioral health authorities are risk-adjusted for the child welfare population and are, on average, 29 percent higher than for non-child welfare involved children.

  In Michigan, child welfare and behavioral health collaborated to develop a strategy for serving children in child welfare with behavioral health challenges who do not meet the criteria for the level of care provided through the 1915 (c) Medicaid Home and Community-Based Services Waiver. Incentive payments are provided to the community mental health services agencies to make it more feasible for them to serve these children through the Medicaid behavioral health managed care system. These incentive payments are over and above the capitation rates for Medicaid children and are targeted to children with serious mental health conditions in foster care or those involved with child protective services.

Eligibility, Enrollment, and Access

- **Presumptive Eligibility** – In all four states, all or nearly all children in child welfare are eligible for Medicaid. In both Massachusetts and Michigan, there is presumptive eligibility for children in child welfare. Making children who enter foster care presumptively eligible for Medicaid can help to ensure more immediate access to health and behavioral health screens and services.

- **Coverage Beyond Age 18** – Medicaid coverage for children in foster care beyond age 18 is a strategy currently used in some states; in 2014, coverage to age 26 will be required under health reform. This coverage is essential for youth and young adults aging out of the foster care system and making the transition to adulthood and independent living. Currently, Massachusetts provides coverage up to age 25 for youth aging out of the foster care system, and in 2008, Michigan increased eligibility for Medicaid to age 21 for youth in foster care if their case closed at the age of 18 or later.

- **Co-Location and Liaisons** – Co-location of health and behavioral health staff and liaisons in child welfare offices has proven to be an effective strategy for assisting with eligibility determination, enrollment, and access to care. To facilitate enrollment and access to physical health services, the child welfare system in Michigan has health liaison officers placed within county child welfare offices. These liaisons are experts in working with the Medicaid health plans and their staff, as well as with child welfare staff and foster families. When a child enters care, the liaison officer facilitates enrollment in a health plan and ensures that health care services continue without disruption if the child transitions to a new foster home or another placement.

  For behavioral health services, children's mental health clinicians placed within Michigan's child welfare agencies work directly with child welfare staff to identify children who are eligible for services under the 1915 (c) Medicaid Home and Community-Based Services Waiver for children with serious emotional disturbances. The services provided by these "access staff" are covered under Medicaid as assessment services. Beyond determining eligibility, the clinicians provide consultation,

assistance in accessing behavioral health services, as well as assistance to child welfare staff regarding children with behavioral health concerns.

In New Jersey, Child Health Units are co-located in each of the 47 child welfare offices across the state. Staffed by nurses, the units work collaboratively with case workers, foster parents, and other caregivers to ensure timely access to medical and dental care for children, particularly those who require specialty care.

Screening and Early Intervention

- **Timeframes for Screens** – Timeframes for physical, behavioral, and dental health screens help to ensure that children entering the child welfare system are assessed quickly for physical and behavioral health concerns and are linked with needed services to intervene as early as possible. In Arizona, an urgent response strategy was jointly developed by child welfare, behavioral health, and Medicaid whereby every child entering foster care receives a behavioral health assessment within 72 hours of entering care. This strategy creates a "fast track" to link a child in foster care with behavioral health services. Massachusetts requires medical screening for children entering state custody within seven days and a comprehensive examination within 30 days, and Michigan requires a full medical examination by a physician within 30 days of a child entering foster care, which includes a behavioral health component.

  In New Jersey, children entering foster care are required to have a physical health examination within 30 days of placement, which is paid for by Medicaid. Through a partnership between Medicaid and child welfare, enhanced rates were negotiated for this comprehensive medical examination. Mental health screening is also required for children in out-of-home placement and also must be completed within the first 30 days.

  The Child Health Units in New Jersey also fulfill a screening function by visiting each child placed out-of-home within two weeks of entering care and thereafter at regular intervals, often with the child welfare worker, to assess health care needs, provide developmentally appropriate anticipatory guidance, and review the child's health care plan with the caregiver. Child Health Unit nurses and case workers are responsible for ensuring that children receive ongoing screening and that children who are identified with suspected mental health needs receive mental health assessments and follow-up care. Similarly, the health liaison officers in Michigan fulfill a screening and assessment function so that physical and behavioral health needs are identified as soon as possible after children enter care.

- **Standardized Screening Tools** – The use of standardized screening tools provides a mechanism for ensuring that children in child welfare are assessed with valid instruments that are sufficiently sensitive to identify their physical and behavioral health needs. All Medicaid enrollees in Massachusetts are required to have a behavioral health screen based on screening protocols and using one of a set of standardized tools. Primary care practitioners receive training on using the tools and linking children with services when behavioral health needs are identified. In Michigan, standard screening and assessment tools are required for younger children on Medicaid and are recommended for older children for their screens under the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit. For children in foster care, a validated, normed screening instrument must be used at each scheduled EPDST well-child visit. There are child health forms specific to child welfare that document that the required medical, behavioral health, and dental screenings have been completed. New Jersey employs a version of the Child and Adolescent Needs and Strengths (CANS) assessment to evaluate children with suspected behavioral health treatment needs.

Covered Services

- **Coverage of a Broad Range of Home- and Community-Based Services** – A robust Medicaid benefit covering a broad range of home- and community-based services and supports, in particular behavioral health services, is essential for children in child welfare to enable them to be served in home and community settings rather than in hospitals and residential treatment centers. The states in our sample all have a rich benefit package that covers a wide array of services and supports (in addition to traditional treatment services such as individual, group, and family therapy; medication review and administration; and evaluation). Covered services include intensive in-home services; Wraparound facilitation or treatment planning; intensive care management; mobile crisis response and stabilization; therapeutic foster care; respite care; family peer support; family training; substance use treatment; therapeutic mentoring; behavioral assistance; and transportation. This has been accomplished in states by adding services to the state Medicaid plan and/or revising service definitions and by using the Rehabilitation Services Option and Targeted Case Management. In addition, some states have used Medicaid waivers to expand coverage.

  Several services are especially important for children and families involved with child welfare. Through intensive in-home services, teams of providers come into the home and community to provide treatment, in-home behavioral support, and education for caregivers on how to manage their child's challenging behaviors. Family peer support offers family partners who have lived experience to mentor, support, and advocate for other families as they progress through the service delivery process. Coverage of family peer support greatly increases the ability to engage families and provides services through a more family-centered approach; it is a significant support to families involved with child welfare, to child welfare staff, and to health care providers.

  Mobile crisis response services provide crisis teams that can respond to crises at foster homes, family homes, shelters, group homes, and other settings and divert children from hospitalization. Some can remain involved with families for a period of time (ranging from one week in Massachusetts to as much as nine weeks in New Jersey) for stabilization purposes rather than risking out-of-home placements.

  In New Jersey, three new services will be added to the Medicaid benefit package as a result of a recently approved Comprehensive Medicaid Waiver – youth support and development, services for youth in transition to adulthood, and non-medical transportation that is a part of a child and family's individualized service plan.

  In some states, Medicaid benefits are supplemented by state funds that are used to finance services or supports that are not Medicaid-billable. For example, New Jersey provides flexible funds to pay for services and supports that are part of the individualized service plan but are not covered by Medicaid, such as tutors or housing assistance.

- **Coverage of Evidence-Based Practices** – Specific strategies are needed to cover evidence-based interventions, particularly behavioral health interventions, relevant to the child welfare population such as Trauma-Focused Cognitive Behavioral Therapy. In Arizona, a separate Medicaid billing code was created for Multisystemic Therapy, and other evidence-based practices are covered using existing codes for assessment, case management, therapy, and others. Billing code matrices were developed to help providers determine how to bill for practices such as Functional Family Therapy, Multidimensional Treatment Foster Care, and Cognitive Behavioral Therapy.

Michigan covers evidence-based practices such as Trauma-Focused Cognitive Behavioral Therapy and Parent Management Training-Oregon Model. Evidence-based practices are covered under Medicaid when delivered by a certified clinician and are covered under billable service codes such as home-based therapy or individual or family therapy. New Jersey covers some specific evidence-based practices (including Multisystemic Therapy and Functional Family Therapy), and the state has supported training in various evidence-based treatments including Cognitive Behavioral Therapy, Trauma-Focused Cognitive Behavioral Therapy, Parent-Child Interaction Therapy, and Brief Strategic Family Therapy.

- **Coverage of Intensive Care Coordination** – Coverage of intensive care coordination at low care coordinator to child ratios (e.g., 1:8-10) is critical for children in child welfare in recognition of their complex needs and multi-system involvement. High-need case management in Arizona was added to the Medicaid benefit and is primarily billed as case management, though some components can be billed under codes for living skills training, family support, and therapy. Community Service Agencies (i.e., care management entities) in Massachusetts provide intensive care coordination financed by Targeted Case Management using a Wraparound practice model, and Targeted Case Management is considered a critical service in Michigan as well. New Jersey also uses Targeted Case Management to help finance intensive care coordination provided through its Care Management Organizations, which also use a high quality Wraparound approach.

Individualized Service Planning

- **Coverage of Wraparound Practice Approach** – Coverage of the Wraparound practice model to support individualized care planning is essential for children and families involved with child welfare based on their complex needs and the multiple agencies and caregivers typically involved in their care. Child and family teams are the lynchpin of the Wraparound practice approach, with a team that is specific to each child and family and includes the family (defined as foster, kinship, birth families, and other involved caregivers) and all other involved providers as well as natural supports that may be identified by the family and youth. The team develops an individualized, customized plan for services based on the youth's and family's strengths and needs, ensures that services are provided and coordinated, monitors progress, and revises the plan as needed. This approach has been successful in avoiding "deep-end" placements.

  In Arizona, the Wraparound process for service planning and delivery is mandated for all children on Medicaid who receive behavioral health services, including those in child welfare. Wraparound facilitation is covered by Medicaid using billing codes including case management and family support. These teams are empowered to determine medical necessity and the service plans they develop are considered to be authorized services for Medicaid. A Wraparound approach to planning and delivering services is also the foundation of Massachusetts' practice model for its Children's Behavioral Health Initiative. Community Service Agencies located in each of the child welfare service areas provide intensive care coordination financed by Targeted Case Management using "high-fidelity Wraparound" as described by the National Wraparound Initiative.[2]

  Wraparound is covered in Michigan's state Medicaid plan so that any child in need can receive this service. The service is provided most frequently to children who are involved in multiple systems and are at risk for out-of-home placement. Similarly, the practice model for the children's behavioral health system in New Jersey is the Wraparound approach. For children involved with child welfare and juvenile justice, the plans must address safety and permanency issues.

Psychotropic Medication

- **Monitoring and Consultation on Psychotropic Medications** – In recognition of the over-prescription and inappropriate prescription of psychotropic medications to children in child welfare, recently highlighted in a U.S. Government Accountability Office (GAO) study, states are strengthening their monitoring of psychotropic medication utilization and consultation to prescribers and child welfare workers. In Arizona, a replica of the GAO study was conducted, and similar concerns were identified – children in child welfare were prescribed psychotropic drugs at a higher rate, polypharmacy was an issue, and many were prescribed higher doses than the maximum levels cited in guidelines, with the potential for serious, adverse side effects. As a result, Medicaid, behavioral health, child welfare, the Medicaid health plan, and the Regional Behavioral Health Authorities are collaborating to determine best practices and update relevant practice protocols.

  In Massachusetts, the state, in partnership with Massachusetts Behavioral Health Partnership (MBHP), a behavioral health managed care organization, has implemented consultation to primary care practitioners on the appropriate use of psychotropic medications, and MBHP has undertaken quality initiatives to address the issue of children with long term use of these medications. In addition, data from the Medicaid pharmacy system are analyzed for the child welfare population to identify outliers, both children and prescribers, so that a system to address these cases can be implemented. The medical director of the child welfare agency will play a major role in following up on identified situations warranting intervention.

  The child welfare system in Michigan hired a child and adolescent psychiatrist as a medical consultant at the state level to focus on child welfare issues, including the prescription of psychotropic medications. An updated policy on these medications requiring a standardized written consent form was implemented in 2012, along with guidelines for psychotropic medications that apply to all Medicaid-enrolled children accompanied by an oversight process. The guidelines include "triggering" criteria that indicate the need for review, and through a partnership with Medicaid, these criteria are cross-matched with the medications prescribed for children in child welfare to identify red flags and outliers. The medical consultant follows up with the prescribing physicians when indicated. A manual on psychotropic medications is being widely disseminated to providers in Michigan, and a YouTube tutorial is being developed as well.

  New Jersey is part of a six-state national quality collaborative coordinated by the Center for Health Care Strategies to reduce the inappropriate use of psychotropic medications in the foster care population. The state created a team comprised of Medicaid, child welfare, and behavioral health to explore next steps to monitor the use of these medications.

Medicaid Providers

- **Inclusion of Skilled Child Welfare Providers and Specialists in the Medicaid Network** – Medicaid providers knowledgeable about the child welfare population and trained in effective practices are fundamental to providing effective care. Providers are needed with expertise that is relevant to children in child welfare such as sexual abuse, attachment disorders, and trauma. A specialty provider initiative in Arizona was undertaken to develop expertise in these areas and to ensure that the Medicaid behavioral health provider networks include providers with these skills. Since the child welfare system had existing contracts with providers with these specialties, it was ultimately mandated that the regional authorities include these specialists in their provider networks. All of these providers were required to become certified as Medicaid providers. The state conducted annual

surveys as part of a "sufficiency process" to determine whether these specialty providers were, in fact, included in the networks.

Provider networks in Massachusetts are required to include expertise in trauma-informed care. A certificate program was implemented at a college in Boston for advanced study in trauma-informed care for the child welfare population. In Michigan, the provider networks of the community mental health services agencies include a variety of specialists to meet the needs of children in child welfare and other populations. When providers with a particular type of expertise are not available, the agencies may seek out a specialty provider that is "out of network."

- **Practice Protocols for Child Welfare Population** – Practice guidelines and protocols for Medicaid providers are used as a strategy to highlight the unique needs of the child welfare population and to outline best practices for responding. Practice protocols were developed in Arizona to guide behavioral health service delivery to children in child welfare that outline procedures for coordinated service planning and delivery. Behavioral health and child welfare collaborated in Massachusetts to develop guidelines for behavioral health agencies and providers on how to work with the child welfare system.

- **Ongoing Training** – Training is needed to ensure that the providers serving the child welfare population have the necessary knowledge and skills on an ongoing basis. In Arizona, behavioral health providers receive training in areas relevant to the child welfare population through modules including "a day in the life of a child in child welfare," clinical needs of the child welfare population, how to work with the child welfare agency and the courts, and others. In Michigan, community mental health services agencies receive training on the unique needs of children in child welfare, in many cases with child welfare staff, foster parents, and others with this expertise serving as trainers. In addition, the mental health agencies provide training to child welfare staff on behavioral health services. Extensive training is also provided statewide on evidence-based practices that are essential for the child welfare population, most notably on Trauma-Focused Cognitive Behavioral Therapy.

  New Jersey has two structures that provide ongoing training on the unique needs of the child welfare population – a Child Welfare Training Academy and a Behavioral Health Research and Training Institute. Both offer vehicles for preparing child welfare, health, and behavioral health providers to work with this high-need population.

Performance and Outcome Measurement

- **Tracking Child Welfare-Related Performance, Utilization, Outcomes, and Expenditures** – A critical strategy to make Medicaid work for children in child welfare is to incorporate and monitor performance expectations specific to the child welfare population and to track service utilization, outcomes, and expenditures for this population. Collecting this information from managed care entities and providers allows Medicaid, child welfare, and behavioral health to make data-based decisions and implement strategies to improve quality and outcomes.

  Arizona established performance standards for physical health services under Medicaid, and the Medicaid health plan for children in foster care is routinely monitored. Under the Medicaid Managed Care Waiver in Michigan, a reporting system provides encounter data that track service utilization, and there is a marker to identify children in child welfare. For children served under the 1915 (c) Medicaid Home and Community-Based Services Waiver, data are collected relative to a set of indicators, and a functional assessment is built into the system using scores on the Child and

Adolescent Functional Assessment Scale. Specific data are produced on outcomes for the child welfare population.

For youth receiving intensive care coordination and mobile crisis services in Massachusetts, detailed reports are produced on various indicators. Data are collected to track indicators specific to the child welfare population, for example, using Medicaid claims and behavioral health data to identify children in child welfare and provide information on this subset of children. An indicator that has been tracked reflects the number of child welfare-involved children in psychiatric hospitals awaiting placement, which has been reduced significantly.

In New Jersey, outcomes-based contracts are used with providers that require information on a number of key indicators, some particularly relevant to the child welfare population such as stability of children and families, well-being, and permanency. Regular data reports are also produced on specific benchmarks for children in child welfare, including benchmarks on physical health and behavioral health services. For example, data are collected on how many children receive pre-placement medical assessments, comprehensive medical examinations, examinations in compliance with EPSDT guidelines, semi-annual dental checks, and immunizations. For behavioral health services, reports are generated on mental health assessments for children with suspected mental health needs and the extent to which they receive timely and appropriate follow-up and treatment.

- **Cross-Agency Data Sharing** – Cross-agency data sharing is a strategy that allows Medicaid, child welfare, behavioral health, and other system partners to communicate and to monitor progress and impact across agencies. In Arizona, the data system from the Medicaid health plan for foster care children and the child welfare system data system interface to share data seamlessly to improve service delivery for children in child welfare.

State Case Studies

ARIZONA

QUICK LOOK: Making Medicaid Work for Arizona's Child Welfare Population

- Medicaid is the platform for a single behavioral health delivery system (behavioral health carve-out) with attention to the needs of children in child welfare
- Enrollment of children in foster care in a single health plan for medical and dental care
- Risk-adjusted rates
- Using child welfare funds to draw down additional federal Medicaid match to expand behavioral health resources
- Practice guidelines and protocols for Medicaid providers related to the child welfare population
- Co-location of behavioral health staff in child welfare offices
- Broad medical and behavioral health benefit, including support services like respite and family peer support
- Urgent response required by Medicaid behavioral health plans when child enters care; screens within 72 hours
- Coverage of the Wraparound approach to service planning and delivery
- Attention to appropriate use of psychotropic medications
- Specialty providers knowledgeable about the child welfare population
- Provider training on needs specific to child welfare population
- Tracking service utilization of the child welfare population

Overview of Arizona's Child-Serving Systems

The child welfare system in Arizona, which is state administered, is housed within the Department of Economic Security (DES). Within this department, the Division of Children, Youth, and Families (DCYF) is responsible for child welfare services, including child protective services, foster care, and adoption, that are provided in five geographic regions.

The Arizona Health Care Cost Containment System (written as AHCCCS and pronounced "access") is the state's Medicaid program, which operates within a managed care environment through an 1115 Research and Demonstration waiver. AHCCCS oversees contracted health plans to deliver health care to individuals and families who qualify for Medicaid and other medical assistance programs.

Arizona has a population of 6.4 million, with Hispanics and Latinos comprising nearly 30 percent, and has the largest number of speakers of Native American languages in the 48 contiguous states. As its population grows, Arizona's child welfare system serves a growing number of children in foster care, today numbering 14,000. Nearly 1.5 million people in the state are enrolled in Medicaid (24 percent of the state's population), with children comprising close to half of the Medicaid population.

Arizona's approach to providing physical and dental health services to children in foster care is unique in that children in care are enrolled into a single Medicaid health plan[i] – the Comprehensive Medical and Dental Program (CMDP) – created specifically for this population. CMDP was established in 1970 by state law and is administered by DCYF. Medicaid contracts with DCYF for CMDP through an Intergovernmental Agreement to serve as the health plan for children in foster care.

[i] Although Medicaid enrollees are required by federal law to have a choice of health plans, in Arizona a waiver of choice for the child welfare population allows these children to be enrolled in one single plan (CMDP) for their physical health services.

Behavioral health care is provided to children in foster through the behavioral health managed care system overseen by the Department of Health Services, Division of Behavioral Health Services (DBHS). The state Medicaid agency contracts with DBHS through an Intergovernmental Agreement to manage the behavioral health system under Medicaid. The division, in turn, contracts with four Regional Behavioral Health Authorities (RBHAs) covering six geographic regions throughout the state and with three Tribal Behavioral Health Authorities. These entities manage behavioral health service delivery for both children and adults in their respective areas.

Background and Collaboration

Arizona state agencies have worked collaboratively to meet the physical and behavioral health needs of children in the child welfare system. CMDP, the medical and dental health plan for children in foster care, was integrated into the state's Medicaid program in the mid-1980s.

> "We pulled together an interagency group of child welfare and behavioral health providers and agency staff to have a frank conversation about how children experience removal from their homes. We talked about the experience from the child's point of view."

In addition, the state has worked extensively to design strategies for improving behavioral health services for this population. Stemming from the recognition of unmet needs, the trauma involved in placement in foster care, and the unique mental health needs of this population, the state created a task force in 2000 to examine mental health services for children in child welfare. Utilizing case reviews and other methods, the task force identified systemic problems that impeded behavioral health service delivery for this population.

A class action lawsuit, referred to as Jason K. or JK, was instrumental in moving this collaboration to a new level. Originally filed in 1991, the JK lawsuit alleged that Arizona had failed to provide the mental health treatment mandated by Medicaid's EPSDT provision. The class of plaintiffs included all Medicaid eligible persons under the age of 21 who were identified as needing behavioral health services. The lawsuit resulted in what has been described as an historic settlement agreement in 2001, committing the state to a complete redesign of its Medicaid children's behavioral health system. Children in state custody due to abuse and neglect were specifically mentioned as part of the class, laying the groundwork for a special focus on this population in crafting the new system. As such, the child welfare system had a significant influence in shaping the settlement agreement.

AZ Medicaid Behavioral Health System Principles

- Collaboration with the child and family
- Functional outcomes
- Collaboration with others
- Accessible services
- Best practices
- Most appropriate setting
- Timeliness
- Services tailored to the needs of the child and family
- Stability
- Respect for the child and family's unique cultural heritage
- Independence
- Connection to natural supports

Through the settlement, a set of principles emerged based on the system of care approach, which calls for individualized services that are: tailored to the needs of each child and family, accessible, coordinated, based on best practices, and provided in the most appropriate setting. Eventually, all child-serving agencies signed onto these principles to meet the behavioral health needs of children in Medicaid. The adoption of the principles led to the development and financing of a Medicaid benefit that today includes a broad array of home- and community-based services and supports, as well as the development of specific goals and protocols for serving the child welfare population that were jointly developed by behavioral health and child welfare.

These child welfare-specific goals include:

- Immediate delivery of behavioral health care through "urgent behavioral health response;"
- Contracts with behavioral health providers that require an understanding of the unique needs of children in child welfare;
- Assessments that better meet child welfare system needs through a strengths-based, individualized, holistic approach that includes assessments of risk, trauma, substance use, etc.; and
- Specialty services available for post-traumatic stress; sexually inappropriate behaviors; loss, attachment, and bonding; family functioning, parenting skills, and family preservation; youth in transition to adulthood; adoption support, etc.

"Although Medicaid controlled the package of services, they looked to behavioral health as the experts to identify what services were needed and significantly expanded the array of covered services."

The partnership among the Medicaid, behavioral health, and child welfare agencies was critical in implementing reforms to address these needs. Leaders in the Medicaid agency were strong proponents of community-based services rather than residential care for children, and as a result, were receptive to recommended changes. The high level of cooperation resulted in coverage for a broad array of services and supports that became effective only five months after the JK settlement.

"Lots of the interaction between agencies is relationship driven, and much is based on trust that each agency will do its fair share."

Building these relationships across agencies took a great deal of work. Following the JK settlement agreement, state agency directors signed a Memorandum of Understanding that has been the foundation for their partnership. A children's executive committee met for a number of years, bringing together agency leaders to chart a common direction, design the system, coordinate, and resolve problems. While the committee is not as active as in the past, the relationships among the agencies continue. As in many states, turnover in leadership presents a particular challenge to maintaining cross-agency relationships, and continual efforts to nurture partnerships are essential. Local children's coordinating councils were created to provide cross-agency leadership in rolling out a new practice approach using child and family teams and to coordinate services across the Medicaid, behavioral health, and child welfare systems.

The federal Centers for Medicare & Medicaid Services (CMS) was supportive of the proposed strategies, allowing the state to move forward in implementing changes to its Medicaid program.

Medicaid Financing and Service Delivery

In Arizona, nearly 94 percent of children in child welfare are eligible for Medicaid. In addition, children in foster care are eligible for transitional coverage upon leaving care, which provides an additional 60 days to enroll in another Medicaid health plan or a private health plan. As the major source of health care financing for this population, the state has implemented strategies to provide high quality, cost-effective physical and behavioral health care to these children.

In 1982, Arizona became the final state to implement a Medicaid program. At the outset, the program was created with a Medicaid Section 1115 Waiver as a demonstration project and has operated under a managed care model from its inception. The waiver gave the state a great deal of flexibility, and as the Medicaid system has evolved, this flexibility has provided a vehicle for tailoring the structure and services to better meet the needs of children involved with the child welfare system along with their families and caregivers.

Physical Health

As the designated health plan for children in foster care, CMDP is responsible for ensuring – in partnership with foster care providers – that children receive appropriate and high-quality health care services. This entity receives a risk-adjusted capitation rate for children in child welfare, which it uses to pay for all medically necessary physical health and dental services for this group. Arizona's Medicaid program also offers reinsurance as a stop-loss mechanism for its contractors, which is characterized as a risk-sharing strategy. (Reinsurance reimburses health plans for cumulative claims that exceed established thresholds during a year.)

"Having a health plan dedicated exclusively to children in foster care allows us to pay attention to their special health care needs and to be fully integrated with the child welfare system."

Each child in foster care is assigned to a primary care provider (PCP) that is selected by the foster caregiver to serve as the child's medical home. Foster parents often know which provider they prefer based on past experience and/or to keep all their foster children with the same practitioner. The role of the PCP includes coordinating heath care services and arranging for specialty health care providers when needed. PCPs are paid on a fee-for-service basis by the health plan.

The CMDP and child welfare data systems interface so that data can be shared seamlessly, for example, to easily identify the services that a child has received. It is noteworthy that on almost every pediatric health care measure, the plan ranks number one among all of the Medicaid health plans in the state.

Behavioral Health

Arizona's child welfare system previously provided behavioral health services to its population through a separate funding stream and provider network, rather than through the state-run behavioral health system, resulting in inefficiencies and fragmented care. Collaborative efforts across Medicaid, child welfare, and behavioral health, particularly following the JK settlement agreement, have resulted in substantial improvements in the delivery and financing of behavioral health care for children in child welfare.

Funding for behavioral health services goes from the Medicaid agency to the DBHS, which operates a managed behavioral health system for children and adults. Services are delivered through contracts with the RBHAs, that then contract with providers. Today, approximately 65 percent of children in child welfare in Arizona are actively engaged in the RBHAs and receiving some type of behavioral health care. One region of the state is currently taking corrective action to increase the penetration rate for this population, since its penetration rate has been approximately 50 percent as compared with 70-80 percent for other regions in the state.

RBHAs receive a pre-paid capitation rate for Medicaid enrollees. Annual actuarial reports are produced to examine utilization and utilization trends, which drive adjustments in capitation rates. The costs over the previous three years are used to justify rates for the next fiscal year. Although RBHAs are at risk, there is a "loss-profit corridor" whereby RBHAs are reimbursed by DBHS for losses in excess of 3 percent. Capitation rates vary across the state's regions based on variation in service expenditures and utilization.

Approximately 15 percent of the Medicaid children enrolled in RBHAs for behavioral health services are involved with child welfare, even though children in foster care represent only about 3 percent of overall Medicaid child enrollment. The system partners acknowledged that the child welfare population has significantly greater treatment needs as compared with other Medicaid-eligible children, and as a result, incorporated provisions specific to child welfare into the Medicaid behavioral health system, including:

- **Capitation rates are risk-adjusted for the child welfare population**. The capitation rates for children in foster care were developed with the assistance of actuaries and are, on average, 29 percent higher than the rates for non-child welfare involved children. With these additional resources, the RBHAs are better able to provide the appropriate intensity and types of specialized services needed by this high-risk group.
- **The child welfare system contributed funds to the Medicaid behavioral health system as Medicaid match**, allowing the state to draw down additional federal Medicaid dollars and generating more resources for services. Fragmentation was reduced by consolidating most behavioral health resources in the Medicaid managed care system.
- **Several practice protocols have been developed for this population**, to guide behavioral health service delivery for children and families involved with child welfare, for example:
  - Procedures for a uniform and coordinated service planning process; and
  - Procedures for service delivery when a child remains with his or her own family; is removed to protective foster care; is returned to the family of origin from foster care; achieves permanency through adoption/guardianship; or is preparing for independent living.

"Child welfare wanted certain guarantees from the Medicaid behavioral health system to feel confident that their children would be served well. The protocols help to demonstrate a good faith effort."

Screening and Early Intervention

One of the most important strategies for serving children in child welfare is urgent response, a rapid approach for screening and early intervention. A protocol for urgent response was jointly developed by Arizona's child welfare, behavioral health, and Medicaid agencies, requiring that every child entering foster care receive an assessment of behavioral health needs within 24 hours of entering care. Due to fiscal constraints, this time window was later extended to 72 hours. Stakeholders indicated that the extension in timeframe still allows them to meet the needs of the child and may even provide a more accurate picture of the child's needs. Providers now have a bit more leeway in conducting the urgent response and in maintaining qualified staff for this purpose. Higher capitation rates for the child welfare population have also allowed the RBHAs to create units with sufficient staff levels for the screening services.

"One impetus for urgent behavioral response was a 2002 newspaper story about a five-year-old girl swept up in the foster care system and placed in a shelter on a weekend with no support or response to this traumatic event in her life."

Urgent response creates a "fast track" to link a child in foster care to behavioral health services. If there is an indication of need, the child is referred to a provider for ongoing services; the urgent response clinician identifies an appropriate provider and coordinates the care. If an immediate referral for ongoing services is not needed, a follow-up contact occurs approximately two weeks after the urgent response visit, and again at four weeks, to check in with the child and caregiver and assess whether needs have changed. Initially, fewer than 30 percent of child welfare-involved children were enrolled in RBHAs. After implementation of the urgent response, enrollment in the RBHAs grew to nearly 65 percent; and today, more than 90 percent of children removed from their homes receive an urgent response screening.

"The urgent behavioral response offers a lifeline to substitute caregivers in foster homes and shelters because they have a contact in the behavioral health system to call who will respond immediately."

Any critical physical health care needs identified during the urgent response screens are brought to the attention of the child welfare worker. A comprehensive medical screening consistent with EPSDT

requirements must then occur within 30 days of entering foster care, and all subsequent EPSDT visits must include developmental and behavioral health screens.

The state's behavioral health system co-locates behavioral health professionals in child welfare offices to conduct assessments and provide crisis services – all of which are Medicaid reimbursable. Child welfare staff have found this extremely helpful.

Covered Services

Arizona's Medicaid billing system was created to anticipate many combinations of services, levels of care, and service settings. Following the JK settlement, the state Medicaid agency added billing codes for the broad array of children's behavioral health services and supports deemed necessary for Medicaid children, including those in child welfare.

> "The highly comprehensive physical and behavioral health benefit provided through Medicaid is richer than most policies in the commercial world."

Arizona's Medicaid program covers a robust package of behavioral health services and supports for children, most of which are heavily utilized by the child welfare population. Despite variations in the availability of some services across the state – for example, in some rural areas – many children and families have access to services and supports that go well beyond traditional behavioral health treatment. These services support foster homes, kinship homes, and other child welfare placements, and allow children to be served in the community, avoiding congregate care placements.

The range of supportive services covered by Arizona Medicaid includes:

- In-home services
- Respite care
- Life skills training
- Family and peer support
- Therapeutic foster care
- Case management
- Supported housing
- Supported employment
- Mobile crisis intervention
- Crisis stabilization
- Respite
- Transportation

Flexible funds and traditional health services (such as Native American traditional health and acupuncture) are intended to supplement the Medicaid service package and are financed with grant funds.

> "The service array has enabled a large reduction in residential beds in the state, and the provider community is better equipped to manage children in child welfare in community-based services than ever before."

Medicaid also covers evidence-based practices through both new and existing billing codes. A specific Medicaid billing code was created for Multisystemic Therapy, while other evidence-based practices are covered using existing billing codes for assessment, case management, therapy, and others. Billing code matrices help providers determine how to bill for evidence-based practices such as Functional Family Therapy, Multidimensional Treatment Foster Care, and Cognitive Behavioral Therapy. Some of the additional evidence-based practices that can be found in various regions of the state include early childhood mental health consultation, Incredible Years, Brief Strategic Family Therapy, Trauma-Focused Cognitive-Behavioral Therapy, and Motivational Interviewing.

Therapeutic foster care is a particularly significant service that was added to Medicaid. The first licensed therapeutic foster homes were implemented in 2003 and were an important vehicle for discharging children from residential treatment by providing the support needed to bring them back to the

community to live in a family setting. Within two years, the number of children in out-of-state placements was reduced from approximately 100 to 20. Therapeutic foster care was seen as highly cost-effective– at only a fraction of the cost of residential treatment. The state's child welfare system works with both the behavioral health and Medicaid agencies in several aspects of the therapeutic foster care program. Only foster homes licensed by child welfare are used for therapeutic foster care. A curriculum for treatment parents was developed jointly by child welfare and behavioral health. Treatment parents work with the child and the child's birth family, particularly when there are potential reunification plans. Through a cost sharing arrangement, Medicaid pays for the therapeutic portion of the service, while child welfare covers the costs of room and board. However, when a child stabilizes, the rate paid to treatment parents drops to that of regular foster homes, creating a challenge for treatment parents, which may result in a placement change.

Another intervention recently added to the children's behavioral health system is referred to as "high-need case management" and is primarily billed as case management under Medicaid. Some of the components of high-need case management can be billed under the codes for living skills training, family support, and even therapy if the case manager has appropriate credentials. Although this service is not limited to children in child welfare, many child welfare-involved children qualify based on their serious and complex needs. The service is provided by a case manager (with a caseload ranging from 8 to a maximum of 20) who facilitates the development of an individualized service plan; arranges and coordinates services; monitors progress; and supports the child and family.

Individualized Service Planning

In Arizona, the Wraparound process for service planning and delivery is mandated for all children in Medicaid who receive behavioral health services, including those in child welfare. Child and family teams are the lynchpin of the Wraparound approach, with a team specific to each child and family developing an individualized, customized plan for services and supports; monitoring progress; and revising the plan as needed.

Child and family teams are typically small for children with less serious and complex problems. However, for high-need children, the teams are comprised of the Wraparound facilitator (usually the high-need case manager), foster family, birth family (as appropriate), youth, child welfare worker, behavioral health provider, other involved providers, and others as needed. Facilitation of the Wraparound process is covered by Medicaid, using case management and/or family support billing codes; the time of some of the other providers may also be covered under Medicaid.

Initially, child and family teams were implemented for children in or at high risk for out-of-home placements, such as residential treatment, many of whom were in child welfare. "Family" was deliberately defined as including foster families, kinship families, birth families, and other caregivers, to be responsive to the various contexts for this population. A practice protocol for child and family teams was developed at the outset with cross-system input for the functioning of these teams and mandating that every involved system be included in the planning.

Child and family teams are empowered to determine medical necessity, and the service plans they develop are considered to be "authorized" services for Medicaid. Only a few designated services – inpatient hospitalization, residential treatment, group home care, and prescriptions for psychotropic medications – require prior authorization outside of the teams. RBHA professionals can approve these services, but denials can only be rendered by a behavioral health medical professional. These four services must meet medical necessity criteria and are subject to utilization review and periodic reauthorization. Emergency placements are retrospectively approved.

The RBHAs have provided extensive training to providers on how to use the child and family team process. The approach has been so well received that the adult system has adopted it, referring to it as "adult clinical teams."

The agency partners are currently working on developing a youth "assent" process, which is a youth empowerment effort designed to engage youth in their own care in an age-appropriate way. The purpose is to provide youth with information and to ensure that they are actively involved in decision making. This process is well aligned with the concept of child and family teams and holds promise for further strengthening youth involvement. A workgroup of youth members developed a practice protocol for youth involvement that went into effect in July 2012.

Psychotropic Medication

As in other states, Arizona is grappling with the appropriate use of psychotropic medications among children in child welfare and whether children are receiving other needed services and supports in addition to or as an alternative to medication. In 2011, the behavioral health and child welfare agencies, and the children's medical directors of the RBHAs began a collaborative process to explore these issues.

Medicaid data were pulled for both physical and behavioral health service use, and a replica of the U.S. Government Accountability Office (GAO) study on this subject was conducted. The results were similar to those found in other states: children in child welfare were prescribed psychotropic drugs at a higher rate; many had regimens that included multiple medications; and many were prescribed higher doses than the maximum levels cited in guidelines, with the potential for serious, adverse side effects. Medicaid, behavioral health, child welfare, the Medicaid health plan, and the RBHAs are now working together to determine best practices, update relevant practice protocols, and determine other necessary action steps.

Medicaid Providers

The Medicaid health plan for physical heath (CMDP) utilizes a network of providers who are willing to see children in child welfare and to accept Medicaid rates. CMDP's provider relations department reaches out to these providers to cultivate relationships through meetings, newsletters, and engagement strategies. These methods also serve as vehicles for disseminating information and training to increase provider capacity for serving the child welfare population.

When behavioral health services for children in child welfare were moved to the Medicaid behavioral health system, the child welfare agency was concerned that RBHAs did not have the expertise to treat their children; so two strategies were implemented to address this concern.

"Initially, there was a huge learning curve for behavioral health providers to serve children in child welfare, but this has been overcome."

1. **A specialty provider initiative** was developed to cultivate expertise in six areas of specialization, including: sexual abuse, early childhood, and eating disorders. Since the child welfare system had existing contracts with specialists in these areas, it was ultimately mandated that these providers become certified as Medicaid providers and that RBHAs include them in their provider networks. The state conducted annual surveys as part of a "sufficiency process" to determine whether these specialty providers were, in fact, included in the RBHA networks. Subsequently, it was mandated that the RBHAs also include developmental pediatricians in their provider networks.

2. **Training modules were developed for behavioral health providers** in areas relevant to the child welfare population. Modules have included: "a day in the life of a child in child welfare," clinical needs of the child welfare population, and how to work with the child welfare agency and the courts, among others. In addition, statewide training has been conducted to develop the knowledge and skills among providers to offer the expanded array of services and supports; web modules were developed for some training components. Throughout the training, emphasis has been on developing skills to meet the unique needs of children involved with child welfare.

The state has also undertaken efforts to develop the expertise to provide trauma-informed care. As part of the behavioral health network development plan, an annual survey is conducted to determine which providers have had training to qualify as specialty providers in trauma-informed services.

Performance and Outcome Measurement

For physical health, Arizona's Medicaid program has established performance standards, and data are routinely collected by the CMDP. Results have shown that CMDP exceeded the statewide average on all 20 Medicaid performance standards. CMDP had the highest rates statewide for access to primary care providers for all age groups combined, adolescent well care visits, and annual dental visits, and exceeded the statewide average for all immunization measures.

For behavioral health, Arizona adopted a small set of outcome indicators in 2005 to be used across all agencies. Child and family teams are required to report on these outcomes twice a year, and based on outcomes reports from thousands of teams, the state found that, in every age band, outcomes were better for children with child and family teams as compared with those without teams. These indicators include: acceptable emotional regulation, avoiding delinquency, achieving success in school, increased stability, living with a family, and decreasing safety risks. The indicators were revised in 2010 to align with national reporting requirements and now include substance abstinence, stable housing, employment, education, arrest-free, and participation in self-help groups.

Behavioral health performance indicators for children in child welfare are not currently reported separately, though the state is considering this option. It was noted that monitoring penetration rates and service utilization for children in child welfare in the behavioral health system is useful in assessing whether this group is being well served. For example, it was determined that in one county, the penetration rate for children in child welfare was significantly lower than in the rest of the state, and a corrective action plan was implemented to improve the response to this population.

Next Steps for Arizona

Arizona has recently experienced significant changes – most notably, turnover among high-level leaders, resulting in shifts in policy directions and priorities. Interviewees stressed the importance of effective communication with new leaders that includes providing information about the strategies in place to improve the Medicaid system for the child welfare population, a historical perspective on the implementation of these strategies, and data showing that they work. Recommitting to the children's executive committee is a desired next step to establish strong partnerships among the new leaders and to reinvigorate and continue the progress that has been achieved.

Improved communication between primary care and behavioral health providers was cited as an area needing attention. Training and support for primary care practitioners in identifying behavioral health problems and seeking appropriate care was also mentioned as a potential next step.

In the largest county in Arizona, an integrated model that combines financing for physical and behavioral health is being implemented for adults with serious mental illness. One behavioral health entity will manage all primary and specialty care for this group; youth of transition age (ages 18-21) are included. Although a similar model has not yet been proposed for children, there is speculation that it may be applied to children in the future. The state is also exploring how health home models under the Affordable Care Act may be applicable to behavioral health services.

Advice to Other States

> "Ensure that you have a shared vision about how the system should work from an operational perspective, not a grandiose theory."

Based on their experience, interviewees suggested strategies that they consider essential in making Medicaid responsive to the needs of children involved with the child welfare system. An overarching recommendation is to ensure that the expertise of all partners is included in strategizing and problem solving about both physical and behavioral health services for the child welfare population. Interviewees felt that it is essential to include individuals who are knowledgeable about the journey of children in child welfare, such as the impact of maltreatment, out-of-home placements, and the need to treat the entire family and caregivers and not just the Medicaid-enrolled child. The need for a shared vision and commitment among child welfare, behavioral health, Medicaid, and other system partners to meeting the needs of children in child welfare was emphasized. Other recommendations include the following:

Physical Health Services

- Establish one Medicaid health plan exclusively responsible for the child welfare population, rather than scattering the population across multiple plans;
- Ensure timely and thorough EPSDT exams through the primary care provider in the child's medical home, including the required developmental and behavioral screens;
- Incorporate into Medicaid an electronic data system that interfaces with the child welfare data system to facilitate enrollment in Medicaid, the provision of timely physical and behavioral health services, communication among providers, and other critical functions; and
- Establish a process and accountability mechanisms for communication between primary care providers and behavioral health providers.

Behavioral Health Services

- Incorporate a rapid response system (using a statewide protocol) to identify urgent behavioral health needs among all children entering the child welfare system;
- Cover a wide array of services and supports for children in Medicaid, with particular attention to services that are important for children in child welfare;
- Implement risk-adjusted capitation rates for children in child welfare so that behavioral health providers have sufficient resources to provide the higher level of services needed by this population and their caregivers;
- Require specialty providers to be included in provider networks to ensure capacity for addressing needs related to trauma, adoption, sexual abuse, attachment disorders, and others;
- Incorporate a child and family team process for service planning and delivery;
- Develop statewide practice protocols for how behavioral health services should be delivered to children in child welfare; and
- Co-locate behavioral health providers in child welfare offices to serve as a primary conduit to the behavioral health system.

Monitoring of Physical and Behavioral Health Care Services

- Establish a meaningful and robust quality improvement process to monitor health care service delivery;
- Track service utilization and outcomes for children in child welfare and publish results to provide information for quality improvement;
- Implement strategic communication strategies using data to demonstrate improved results, cost savings, and impact on children in foster care to use with policy makers such as agency executives, legislators, and other key stakeholders.

Focus on Sustainability

- Institutionalize strategies for serving the child welfare population in policy, contracts, and other vehicles to ensure continuity;
- Recognize that policies and practice protocols must be supported by ongoing training, monitoring, and quality improvement strategies;
- Start with small victories, such as focusing on 100 children who are in out-of-state treatment facilities, and determine how to ensure access to home- and community-based behavioral health services when they are brought home; and
- Keep the focus on specific, concrete strategies to achieve agreed-upon goals among all system partners.

"It's essential to maintain strong leadership, high priority, and passion for supporting the highly vulnerable children in child welfare through whatever political or administration changes may occur."

Conclusion

The experience of stakeholders in Arizona underscores the importance of focusing not only on aligning Medicaid and behavioral health systems to the unique needs of children in the child welfare system, but also on the quality of the implementation of these strategies. Specific provisions for this population may be well thought out and supported by policies, procedures, protocols, financing, and other vehicles, however, these strategies must also be implemented with fidelity to the intention and monitored to identify areas for improvement. Clear, formal expectations, supported by training, are needed to ensure that providers throughout the system are prepared for successful implementation. Further, performance indicators and routine monitoring are essential for providing reliable information to track performance, assess progress, identify problems, and improve implementation. Finally, a focus on sustainability is key.

ILLUSTRATING THE IMPORTANCE OF ARIZONA'S EFFORTS: Maria and Josie*

Maria was removed from her home in the middle of the night at age five, placed in an emergency shelter and then in foster care. She began wetting the bed, refusing to talk, and crying often. Her foster mother could not find a Medicaid provider available or with the experience to see Maria. The child welfare system ultimately paid for a therapist, but the process took several weeks to put in place. Shortly thereafter, Maria was reunited with her family and was no longer able to see the therapist through the child welfare system. Although Maria remained eligible for Medicaid based on family income, her therapist was not a Medicaid provider. Maria began to regress in her behavior, aggravating tension within the family.

Contrast Maria's experience with that of Josie, who also was removed from home at a young age. The Medicaid behavioral health system through its urgent response team ensured that Josie received a behavioral health screen within 72 hours of being removed and linked her to a Medicaid provider trained in trauma-informed care. When Josie was reunited with her family, she continued to see her therapist, and her family received peer support services and respite.

**Note. These are not actual case vignettes; they are representative to illustrate the differences for children as a result of state efforts to strengthen Medicaid for children in child welfare.*

MASSACHUSETTS

QUICK LOOK: Making Medicaid Work for Massachusetts' Child Welfare Population

- Mandated behavioral health screening as part of EPSDT screens
- Coverage of broad array of home- and community-based services
- Use of Targeted Case Management to support an intensive care coordination approach using high quality Wraparound
- Coverage of family peer support
- Coverage of mobile crisis intervention model that allows longer-term involvement of crisis team with the child and caregivers
- Coverage of youth in foster care to age 25
- Presumptive Medicaid eligibility for children in foster care

Overview of Massachusetts' Child-Serving Systems

The child welfare system in Massachusetts is administered by the state Department of Children and Families (DCF), which is charged with protecting children from abuse and neglect and strengthening families. DCF has four regional offices and 20 area offices across the Commonwealth; a central office in Boston provides support to the field offices. Of the 40,000 children served by the department, approximately 85 percent remain in their homes, and about 8,000 are in foster care.

Massachusetts is the third most densely populated state in the country, with a population of 6.7 million, and two-thirds of its population living in two metropolitan areas – Greater Boston and Springfield. Massachusetts has about 8,000 children in foster care, and serves over 1.3 million individuals through the Medicaid and Children's Health Insurance Programs, with nearly half being children.

The state's Office of Medicaid is part of the Executive Office of Health and Human Services (EOHHS). This office oversees MassHealth, which is the public health insurance program for low-income residents and is comprised of both Medicaid and the Children's Health Insurance Program. MassHealth, which serves more than 1.3 million members, includes four fully capitated managed care organizations (MCOs) providing physical and behavioral health care, and one Primary Care Case Management (PCCM) program that partners with a capitated behavioral health carve-out (Massachusetts Behavioral Health Partnership – MBHP) for mental health and substance use disorder services. MBHP serves over 20,000 children involved with DCF and the Department of Youth Services, the state's juvenile justice agency.

The Department of Mental Health (DMH) serves as the state mental health authority. DMH is organized into three geographic areas, each of which is managed by an area director and is divided into local service sites that provide fee-for-service case management services and oversee behavioral health services for adults, children, and adolescents in partnership with the state Medicaid agency. Similar to child welfare, the central office in Boston supports the regional and local sites.

Background and Collaboration

"The group had honest conversations about the needs of children and what they could do to address the needs."

DCF has worked collaboratively with MassHealth, MBHP, and DMH to ensure that children involved with the child welfare system receive appropriate health and especially, behavioral health services. The various Medicaid provisions that benefit the child welfare population emerged from complementary reforms in these three systems that have evolved over the past decade and a half. Child welfare was shifting its practice model, increasingly emphasizing home- and community-based services and services "at the front door," i.e. for families first coming to the attention of child protective services, to reduce out-of-home

placements. A Medicaid Section 1115 Research and Demonstration Waiver, first implemented in 1997, allowed the state to develop alternatives to psychiatric hospitalization and supports for families with many risk factors, including families with children at risk for abuse and neglect. During the past decade, Massachusetts' behavioral health system had already implemented pilot programs based on the system of care approach. For example, the Massachusetts Mental Health Services Program for Youth (MHSPY) involved transferring funds from child-serving agencies to Medicaid to implement population-based, case-rate financed behavioral health services for children with serious behavioral health problems using a Wraparound approach and intensive care coordination. A system of care steering committee was also created at the state level that included representatives from all child-serving agencies at the deputy commissioner level.

Even as these reforms evolved and converged, a class action lawsuit was filed in federal court against the state's Medicaid program. The lawsuit, referred to as "Rosie D." after the lead plaintiff in the case, alleged that the state had failed to provide appropriate services under Medicaid's EPSDT mandate, and that as a result, Medicaid-eligible children with behavioral health problems were placed in hospitals and residential treatment centers unnecessarily. The court ruled in 2007 that the state's Medicaid program was out-of-compliance with EPSDT, and required that the Medicaid program be restructured to provide an array of community-based services and supports, including screening, intensive home-based services, intensive care coordination, family peer support, crisis management, and in-home therapeutic supports.

Following the court order, Medicaid, behavioral health, child welfare, juvenile justice, and other agencies worked collaboratively to design and implement a new system. The effort was named the Children's Behavioral Health Initiative (CBHI) and was led by EOHHS. To reflect the importance of the cross-agency partnership, an interagency leadership team was established that oversees activities related to the CBHI. Although strategies related to Rosie D. were designed to meet the needs of all Medicaid children with serious behavioral health disorders, a significant proportion of these children are involved with the child welfare system. As a result, the child welfare agency was a "major player" in the process and brought attention to the unique needs of its children and to effective approaches for addressing them.

> "The Medicaid agency has been very receptive and open to thinking about ways that Medicaid dollars could be used to meet the needs of the child welfare population more effectively, and has been a willing participant in the work."

Throughout the reform process, child welfare and Medicaid have had a strong partnership. The child welfare agency meets with Medicaid regularly to address problems, craft creative solutions, and implement enhancements. Similarly, the behavioral health system has a Medicaid liaison who is the "go-to" person for handling the interface.

The state-level, interagency CBHI Executive Committee continues to meet monthly to address emerging problems and to design and implement new initiatives such as a joint procurement for some services. System of care committees at the local level were created to convene child-serving agencies as a vehicle for collaboration and for addressing important service delivery issues. Child welfare, Medicaid, and behavioral health are important members of these interagency entities. Although the effectiveness of the local committees varies across the state, primarily based on local leadership, interviewees described a "culture of collaboration and cross-pollination" at both the state and local levels.

The remedial plan for Rosie D. included the requirement that the Commonwealth seek approval from CMS for its reforms. The ensuing negotiations have focused primarily on expanding the array of services that is covered under the state's Medicaid plan. The state prepared many materials to support the proposed changes, and numerous meetings and phone calls were used to explain the service expansion

and to provide CMS with information about the potential impact of these services on both outcomes and cost. With the exception of crisis stabilization units (where room and board costs were challenged by CMS as being neither clinical nor medically necessary), the proposed "remedy services" were approved by CMS. These included: intensive care coordination utilizing a high-quality Wraparound approach, family peer support and training, in-home therapy, therapeutic mentoring, in-home behavioral services, and mobile crisis intervention. A fundamental challenge identified by interviewees is that CMS considers Medicaid to be an insurer responsible for covering medically necessary services, rather than a human services agency with a mandate to protect children or provide support services to children and families, like the child welfare or behavioral health systems. However, Massachusetts paid particular attention in their Medicaid service descriptions to the medical necessity of supportive services, such as family peer support, in garnering CMS approval.

> "Throughout the negotiations, the primary concern of CMS was that the covered services would be clinical and medically necessary."

Medicaid Financing and Service Delivery

The primary financing mechanism in Massachusetts' Medicaid program for both physical and behavioral health services is the Medicaid 1115 Waiver, in place since 1997. In addition, the Medicaid Rehabilitation Services Option has allowed the state to provide Medicaid reimbursement for a range of services and supports that allow individuals with disabilities to live independently in their homes and communities, including children with serious behavioral health challenges. Coverage of Targeted Case Management has been used by the state to help specific groups of enrollees (such as children with behavioral health disorders) access medical, behavioral health, social, educational, and other services. All of the behavioral health remedy services for Rosie D. are financed through state plan amendments under Targeted Case Management and the Medicaid Rehabilitation Services Option.

Physical Health

Massachusetts has a Medicaid managed care system to provide both health and behavioral health services. Physical health services are provided by four MCOs under contract with Medicaid and one PCCM program. PCCM is a system of managed care used by state Medicaid agencies in which a primary care provider is responsible for approving, coordinating, and monitoring an individuals' care for a monthly case management fee, in addition to fee-for-service reimbursement for treatment. Children in child welfare receive a medical passport that is used for identification, linking to primary care providers, ensuring regular visits, and preventing redundancy.

To maximize flexibility and continuity of care, the child welfare agency wanted to retain the ability to choose the MCO for children in foster care. Accordingly, the procurement of physical health care is the responsibility of the child welfare worker, and the choice of health plan and primary care provider can be made on an individual basis. Despite this option, most children in child welfare are enrolled in the PCCM program, which reportedly has a more robust provider network to serve high-risk children and families with bio-psychosocial challenges. As a result, most children in child welfare, as discussed below, receive behavioral health services through MBHP, the behavioral health carve-out associated with the PCCM program.

Contractually, the MCOs and PCCM program are mandated to establish relationships and work closely with state agencies. In addition, EOHHS developed protocols with input from MassHealth, DCF, and DHS to guide how Medicaid and its health plans will work with child welfare. Interviewees noted that efforts are still needed to ensure that these are routinely followed in the field.

Contracts with MCOs are financed through a capitation payment that includes reimbursement for both service delivery and administrative costs. In turn, MCOs contract with provider networks and negotiate rates for each covered service. Providers are paid on a fee-for-service basis. Prior authorization is required for some services, but most service requests are approved, particularly for children in child welfare. Authorization is not needed for emergency or outpatient services. The PCCM program is not capitated for physical health services; rather, primary care providers receive enhanced reimbursement. However, the behavioral health carve-out, through which PCCM-enrolled members receive their behavioral health care, is fully capitated.

Capitation rates are adjusted based on experience. Although there are no special, risk adjusted rates for children in child welfare, the previous costs of serving this population are factored into the capitation rates, which are adjusted annually.

Behavioral Health

The four MCOs and the PCCM program cover the same Medicaid benefit, including the home- and community-based services added to the Medicaid state plan as a result of Rosie D. The Medicaid benefit includes 12 outpatient visits for behavioral health services without prior authorization. In addition, the state worked with all of the MCOs to ensure that common utilization management parameters would be used for the new home- and community-based services under Rosie D. and that the integrity of care plans developed by child and family teams would not be threatened by restrictive prior authorization criteria.

Most children in child welfare receive their behavioral health services through MBHP, which receives capitation payments from Medicaid, as well as administrative payments to provide network management and support services to the PCCM program. To build the infrastructure for the CBHI, MBHP and the four MCOs procured a network of care management entities, called Community Service Agencies (CSAs), to serve children with serious behavioral health challenges. There are currently 32 CSAs – one in each of the 29 child welfare service areas, and three specialty CSAs – that serve any child meeting the criteria for intensive care coordination. The CSAs utilize the Wraparound practice model, intensive care coordination, and family peer support provided by family partners. The specialty CSAs, with particular expertise in serving children and families from African American and Latino backgrounds, as well as children with hearing impairments and their families, were added to the network to bring their organizations' expertise into the CSA provider community. All CSAs are required to serve any eligible child and family seeking services.

Child welfare helped to develop the criteria for the CSAs, and the managed care companies procured the CSAs based on these criteria. Most of the agencies that became CSAs were already providers of behavioral health services in Medicaid provider networks. Many also had previous contracts to provide services to the child welfare population and, therefore, had relevant experience and skills.

> "The nuances of being involved with child welfare are many – relationships, custody, permanency, trauma, and changes in status. It is important that the CSAs be attuned to these needs to provide effective care."

Locating the CSAs in each child welfare service area makes it possible for the CSAs to develop strong partnerships with the child welfare agency and its leaders at the local level. These relationships have raised sensitivity among behavioral health providers to the unique needs of children in child welfare.
Unlike many care management entities, the CSAs currently do not receive case rates or other types of bundled payments. All services provided by CSAs are covered by Medicaid and billed individually on a fee-for-service basis, although the state is interested in exploring a case rate approach. Children in child

welfare are eligible to receive CSA services if they meet medical necessity criteria. The state created manuals for its various child-serving agencies to detail "how the CSA works for your kids." These manuals were developed by CBHI staff in partnership with each of the child-serving agencies.

Eligibility, Enrollment, and Access

The vast majority of children in child welfare are eligible for Medicaid; only a few have private third party liability. There is presumptive eligibility for children in foster care and coverage up to age 25 for youth aging out of the foster care system to ensure that they receive needed medical and behavioral health support as they make the transition to adulthood. Medicaid eligibility is established when children are in the care or custody of DCF, have an adoption or guardianship subsidy agreement, are not in placement and have no or inadequate health care coverage, or are returning home on a trial basis. If parents are not Medicaid eligible, the child welfare system often uses its own resources to provide services to family members (such as substance use services), particularly when reunification is the goal. When children in child welfare are enrolled in the PCCM program, they are automatically enrolled in the behavioral health carve-out, MBHP.

Screening and Early Intervention

DCF has a rigorous approach to ensure that children in child welfare have annual physical and dental exams. Children entering state custody must have a medical screening within seven days and a comprehensive examination within 30 days.

"The screening process was not proactive to identify behavioral health problems early and intervene before they became more serious. Now, behavioral health screening is routine for children in child welfare, using reliable instruments."

Prior to Rosie D., the screening provided during well-child visits under the EPSDT mandate for children in Medicaid focused primarily on physical health, and behavioral health screening was only sporadically included, if at all. Even when screening occurred, referral for behavioral health services did not routinely follow. The premise of the Rosie D. lawsuit was that children were not being screened for behavioral health issues, and as a result, were treated in expensive, high-end placements rather than in the least restrictive setting. The remedy required that behavioral health be a component of EPSDT screens and that the screens be consistent and standardized. The state was required to implement screening procedures for primary care physicians with a behavioral health component using standardized tools. Medicaid billing codes were modified to ensure reimbursement for the screening.

All Medicaid enrollees under age 21 are now required to have a behavioral health screen. Screening protocols were developed, and rather than mandating one screening tool, a core set of options was approved by Medicaid for use during well-child visits. These tools include:

- Ages and Stages Questionnaires: Social-Emotional;
- Brief Infant-Toddler Social & Emotional Assessment;
- Modified Checklist for Autism in Toddlers;
- Parents' Evaluation of Developmental Status;
- Pediatric Symptom Checklist;
- Pediatric Symptom Checklist – Youth Report;
- Strengths & Difficulties Questionnaires; and
- Patient Health Questionnaire 9 – Depression Screener.

Currently, approximately 70 percent of children enrolled in Medicaid are screened for behavioral health issues during well-child visits.

Many stakeholders were involved in developing the screening protocols. Child welfare and Medicaid worked together to achieve consistency in procedures and tools to the extent possible. The work was done with strong support from leaders in the pediatric community, and experts in screening were enlisted as advisors. Once the protocols were completed, primary care practitioners received training on how to use the various tools and how to refer children with identified behavioral health needs for services. Thirteen such sessions were held around the state. In addition, a screening toolkit was developed, as well as online training materials, telephonic and on-site consultation, and a community of practice around assessment. A small group of developmental pediatricians was hired by the MCOS and MBHP to develop the training and the toolkit, and they serve as faculty for the training. These activities were funded with MCO and MBHP administrative dollars.

Additionally, child psychiatrists are on staff and available to provide consultation to DCF on behavioral health issues, including case-specific consultation provided during designated office hours. The Massachusetts Child Psychiatric Access Project (MCPAP), an initiative of MBHP and Medicaid, also provides pediatricians with free, real-time telephonic access to child psychiatry consultation. MCPAP has regional sites across the state with teams of psychiatrists and social workers that are available to any pediatrician.

These changes have resulted in significantly enhanced screening for behavioral health problems in the child welfare population. Ongoing work is focused on enhancing screening to explore the child's history of trauma, a critical area for children in child welfare.

Improvements were also implemented for comprehensive behavioral health assessments for children identified with behavioral health conditions. The child welfare agency had already adopted the Child and Adolescent Needs and Strengths (CANS) for the population requiring residential services, and this tool has now been adopted for use by behavioral health providers. The CANS is now part of an initial behavioral health assessment for Medicaid enrollees under age 21 with identified behavioral health concerns, and providers must update it every 90 days as part of a treatment plan review. The CANS is also used by the CBHI to determine if a child meets the criteria for serious emotional disturbance, to aid in decision support for care planning, and to track progress and needs over time.

Overseen by EOHHS, Massachusetts' versions of the CANS were developed by an interagency committee that included Medicaid, behavioral health and child welfare. Two forms comprise the Massachusetts CANS (Mass CANS) – CANS Birth through Four and CANS Five through Twenty. The goals were to ensure comprehensive assessments; provide a common language for communication about child and family needs; increase awareness of strengths; and increase awareness of culture as a factor in assessment and treatment. A trauma module for the CANS has been developed, and the state is considering adding this as a requirement.

Covered Services

Rosie D. resulted in Medicaid coverage for a significantly expanded array of services and supports, enabling children with serious behavioral health problems to be served within their homes and communities rather than in hospital or residential treatment settings. Referred to as the "remedy services," these newly covered services under the state's Medicaid plan have resulted in marked improvements in care for all Medicaid-enrolled children, including the child welfare population, which received particular consideration throughout the planning process for expanding services.

Previous pilots in Massachusetts yielded valuable information about the services and supports that would be critical to include in the expanded array. The state implemented new home- and community-based services, including in-home therapy, family support and training, mobile crisis services, and therapeutic mentoring, among others, and required that they be planned and delivered through an individualized, Wraparound approach.

In-home therapy is particularly critical for the child welfare population, as traditional outpatient therapy is largely ineffective for this group. Through this service, a therapist and bachelor's level staff person provide treatment in a patient's home (birth, foster, kinship), which includes behavioral support and education for families or caregivers on how to manage their child's challenging behaviors.

"This says to families that we're here to help you, bring out your strengths, and help your children. However, it is also made clear that the interests of the child are paramount and that if abuse or neglect is observed, it will be reported to the child welfare worker."

Under the category of family support and training, family partners who have lived experience can mentor, support, and advocate for other families as they progress through the service delivery process. Medicaid coverage of family peer support has greatly increased the ability to engage families and provide services using a more family-centered approach. The service has been very well received, with many parents requesting this type of support. Interviewees underscored the relevance and importance of family partners, both for families involved with child welfare and as a support to child welfare staff and providers.

"Medicaid has brought this (peer support) service in a big way. Parents who have been there can work with other families to be advocates for them in the system."

Another addition to the array was mobile crisis intervention, which is now the way emergency services are provided to all Medicaid-eligible children in Massachusetts. Crisis teams go to foster homes, family homes, shelters, group homes, and other settings to respond to the crisis and divert children from hospitalization. Initially available for 72 hours, mobile crisis teams may now remain involved for seven days to see the child and family through the crisis rather than risking an out-of-home placement. Continuing efforts are underway to ensure that foster families and others know this service is available and to call the local crisis team rather than the police or an ambulance for behavioral health crises. Child welfare workers and caregivers have found the mobile response and stabilization service to be enormously beneficial as it helps to avoid traumatic experiences with police, ambulances, and hospital emergency rooms, as well as placement disruptions.

If a child needs a residential treatment or group home placement, the team follows the child into the setting and continues working with the family, providing for greater continuity. If a child begins services while in a group home or residential treatment center, the residential provider must continue to provide services after the child returns to the community by working with the home and school and providing respite when needed to ensure stabilization prior to withdrawing. Medicaid reimburses only the clinical services delivered in a residential treatment setting for Medicaid-eligible children. The child welfare and behavioral health systems have made significant progress in creating a joint procurement for residential services to create a more seamless continuum of care.

Formerly, if a family had a family partner financed by Medicaid, that service would be discontinued if their child entered a residential treatment center through the child welfare system. The state is now shifting the payer for family support and training so that child welfare will cover the cost of the family partner while the child is in a residential treatment setting.

Massachusetts is one of five states that received a grant from the federal Administration for Children and Families to provide trauma-informed treatment to the child welfare population. The child welfare agency has worked closely with Medicaid to develop strategies for enhancing provider skills in trauma-informed treatment approaches.

Individualized Service Planning

An individualized approach to planning and delivering services is the foundation of the state's practice model for the CBHI. The CSAs provide intensive care coordination (ICC), financed through Targeted Case Management, using "high-fidelity Wraparound" as described by the National Wraparound Initiative. This particular practice approach was adopted to best meet the needs of children with serious and complex behavioral health problems who are involved with multiple agencies and providers. An individualized child and family team creates a plan of care for the child, with support from all involved agencies, and formal and natural supports. An estimated 30 percent of the children receiving ICC are involved with the child welfare system, and their child welfare workers are central players on the team.

The central tenet of ICC is putting the family at the center of the planning process. Families are defined as foster, kinship, birth families, and other involved caregivers. A care coordinator works with the youth and family to create this team. The team completes a risk management and safety plan; conducts a comprehensive home-based assessment of the youth's and family's strengths and needs; identifies goals; develops an individual care plan that guides the family and team in achieving goals; and ensures that the services and supports identified on the individual care plan are in place and coordinated. This approach has been successful in meeting the needs of children and families involved in child welfare and in avoiding "deep-end" placements for treatment such as hospital and residential care. Children must meet medical necessity criteria to be eligible for ICC, and prior approval is required. However, access is rarely a problem – over 99 percent of requested service authorizations for remedy services are reportedly approved by the MCOs and MBHP.

> "There is now someone whose sole responsibility is to convene and facilitate the service planning process, break down barriers, and engage all involved agencies to participate and develop a single plan of care."

Before ICC was implemented, child welfare had been using family team meetings to plan and provide services. In addition, Medicaid has supported a number of pilot initiatives across the state that embraced the concept of an individualized, Wraparound approach. In the development of the remedy services for Rosie D., it was determined that the Wraparound process should be a Medicaid-covered service under the state plan. As a result, there is now a dedicated, Medicaid-financed care coordinator to facilitate individualized planning and to ensure coordination across agencies.

One of the most important "value-added" provisions according to child welfare is when a child is in a 24-hour setting and presents a combination of clinical, custody, and disposition issues. A care manager is now assigned to each child in custody who is admitted to a 24-hour setting, and planning occurs in the setting with the close involvement of the child welfare worker and family. Joint treatment planning can then occur, and discharge and transfers can be expedited.

Medicaid Providers

With the advent of the CBHI, the state mandated that all of the MCOs have the same core network of providers for the remedy services. This requirement is particularly helpful for children in child welfare. If a child changes to a different placement, there is an opportunity for the child and family to remain with the same providers. If a child moves to a different region where that is not possible, at minimum they can receive comparable services.

Efforts have been made to prepare behavioral health providers for working with the child welfare population and to help the various child-serving agencies learn how to access and navigate the new behavioral health system. Protocols, developed by CBHI staff in collaboration with DCF staff, provide guidelines to behavioral health agencies and providers, including one on how to work with child welfare.

Efforts have also been directed at developing skills among Medicaid behavioral health providers that are especially relevant to child welfare. In particular, the MCOs and MBHP are required to establish provider networks that include expertise in trauma-informed care. A certificate program was implemented by Simmons College in Boston for advanced study in trauma-informed care for the child welfare population.

Although there are no requirements to include other areas of expertise in provider networks, the MCOs and MBHP are obligated to work with child welfare workers to find an agency or therapist with specialized skills when necessary (e.g., sexual abuse) and to contract for these services out of network if necessary. Massachusetts is resource rich in terms of behavioral health professionals, and many of the MCO and MBHP provider networks include highly skilled clinicians who are trained in such evidence-based practices as Trauma-Focused Cognitive Behavior Therapy and Multisystemic Therapy.

Psychotropic Medication

MassHealth (Medicaid) has implemented efforts to address the use of multiple psychotropic medications among children, with a particular focus on: children prescribed more than four medications, those receiving two or more in the same class, and children under five receiving psychotropic drugs. These efforts were spurred by the 2006 death of a four-year-old girl on multiple psychotropic medications, as well as a report from the state's inspector general on overprescribing of these medications. A work group examined this issue specifically for children in child welfare.

Although it is considered a work in progress, several procedures have already been implemented to address issues related to the prescription of psychotropic medications. Data from the Medicaid pharmacy system is being analyzed for the child welfare population to identify outliers – both children and prescribers – so that a system to address these cases can be implemented. The medical director of the child welfare agency will play a major role in following up on situations warranting intervention. In addition, at the direction of Medicaid, MBHP has implemented the MCPAP program that provides consultation services to primary care practitioners at no cost. This program enables primary care practitioners to call and speak directly to a child psychiatrist regarding behavioral health symptoms, diagnoses, and medications. The service is available to any primary care practitioner, regardless of whether the child is covered by Medicaid or other insurance.

Although many providers are on board with changes in medication prescription, particularly for children in child welfare, additional work is needed to shift the thinking and practices among other physicians in the state.

Performance and Outcome Measurement

The Rosie D. remedy requires that data be collected on the outcomes of behavioral health services, and regular reports are generated on specific indicators. For all remedy services, the state produces detailed reports on access to services including waiting lists, utilization of services, and average hours of various services provided per month. For youth enrolled in ICC, data include patterns of use for other remedy services, referral source, length of time from request to first service, discharge reason, length of stay, caseloads, and staffing levels. For mobile crisis services, the state tracks the location of the intervention

(e.g., home, community, provider location, school), the disposition, the length of the intervention, and compliance with the access standard, which is within one hour of the call seeking services. To track the success of mobile crisis in connecting youth to follow-up services, the state monitors their utilization of any other behavioral health services pre- and post-encounter. The state is also working on methods for analyzing CANS data to measure changes in the functioning and status of youth, and findings will be included in public reports in the near future.

Some data are collected to track indicators specific to the child welfare population. For example, Medicaid claims data and data from MBHP both identify children in child welfare and can provide information for this subset of children on Medicaid. One indicator that has been tracked reflects the number of child welfare-involved children in psychiatric hospitals awaiting placement, which has been reduced significantly. Decreases in hospital readmissions and more consistent follow-up have also been found.

Two years of case reviews have been conducted by the Rosie D. court monitor for children served through ICC and in-home therapy, with the experience of 124 children per year examined using the Community Service Review. Findings indicate that the individualized approach used by the CSAs and the broad array of services and supports are achieving positive results; two-thirds of the youth made favorable progress. The effectiveness of this approach in engaging and serving children and families involved with child welfare is an important lesson learned.

> "The reviews have found that the system of care approach and Wraparound process have provided an effective method of serving children with serious behavioral health problems and a powerful way of engaging families involved with the child welfare system."

Next Steps for Massachusetts

Interviewees noted a number of potential next steps that will further Massachusetts' progress in making Medicaid work for children in child welfare:

- **Incorporate more evidence-based practices**. Although the state offers a rich Medicaid benefit, cost sharing among Medicaid and other agencies is needed for EBPs like Multisystemic Therapy or Multidimensional Treatment Foster Care, which provide cost-effective alternatives to residential treatment.
- **Develop appropriate substance use treatment for youth**, as well as treatment for youth with co-occurring substance use and mental health disorders.
- **Enhance training and workforce development**. Efforts are underway to create a Center of Excellence that would support the work of the CBHI.
- **Provide training for front-line child welfare staff.** Much training has been provided for supervisors and leaders, but less for front line staff, creating some challenges in implementing the new approaches and processes.

> "Shared training leads to shared values, a shared sense of best practices, and shared skill building."

- **Increase the number of transitional care units for children in hospitals** who no longer require treatment in that setting but who are awaiting a more permanent placement. In some cases, it is difficult for child welfare workers to identify placements, arrange pre-placement visits in foster homes, and complete other necessary preparations as quickly as they would like. These services would allow foster parents to have an opportunity to shadow workers in the facility and/or receive training on how to handle the child's behavior prior to discharge. A blend of Medicaid and child welfare funds has been used to support some of these strategies, however financing for transitional settings and for implementing some of these strategies to support transitions more broadly would be helpful.

In addition to these improvements, Massachusetts is exploring a state plan amendment for children with serious emotional disturbances that would use the CSAs as health homes for children under the ACA. Many of the services specified under the ACA for health homes are already being delivered by the CSAs.

Advice to Other States

- "Don't wait for a lawsuit," but rather be proactive in assessing system needs and taking action. Massachusetts is currently facing another class action suit (Connor B.) that accuses the child welfare system of failing to provide adequate permanency and safety services for children in foster care. Energy and resources are being spent on years of discovery and depositions – resources that could be devoted to improving the system.
- Develop a mechanism for blended funding across state child-serving systems to increase flexibility in how services are delivered.
- Incorporate a robust behavioral health benefit in Medicaid that includes a range of home- and community-based services and supports that are individualized and flexible.
- Adopt the Wraparound process as the model for service delivery, as it is a very powerful approach in engaging families and caregivers in services, partnering with professionals, and providing individualized, coordinated care.
- Enhance expertise in provider networks in areas relevant to child welfare, such as attachment disorder, sexual abuse, and trauma-informed care.
- Provide information and training to managed care vendors so that they are fully attuned to the unique needs of the child welfare population.
- Breakdown silos between child welfare, Medicaid, and behavioral health systems by increasing each system's knowledge of the others' functions, mandates, and operations. Explore the creation of a children's cabinet that sends a clear message that the agencies are unified, competition is reduced, and the stage is set for effective collaboration.

Conclusion

Collaboration has been the key to making Medicaid work for children in Massachusetts' child welfare system. Partnerships, buy-in, and commitment are needed at three levels – among high-level executives, middle managers with content expertise, and front-line staff who truly implement policies as they work with children and families. Progress in the state has been based on an understanding by Medicaid of the needs of the child welfare population, and by an understanding on the part of the child welfare and behavioral health agencies of what Medicaid can and cannot do in response to these needs. Despite progress, system improvements are still needed; however, the structures and intentions to continue work and solve problems remain strong.

> "Over the years, the spirit of collaboration that has been developed among Medicaid, child welfare, behavioral health, and other systems has been outstanding. There is a willingness to work together as a team, meet regularly, and solve problems."

ILLUSTRATING THE IMPORTANCE OF MASSACHUSETTS' EFFORTS: Brian and Sean*

Brian was removed from home at age 10 for suspected sexual abuse by his stepfather. Brian's foster mother took him to her family pediatrician, who was a Medicaid provider, but the pediatrician found no significant physical health issues. When Brian entered middle school, he began acting out in sexually inappropriate ways. His child welfare worker arranged for him to see a therapist, but Brian was sullen in therapy sessions and increasingly defiant with his foster parents. At age 13, Brian was accused of molesting a younger classmate and became involved with the juvenile justice system. The court recommended that Brian be placed in a residential treatment center specializing in serving youth with sexually aggressive behaviors.

Contrast Brian's experience with that of Sean, who also was removed from home at age 10 for suspected sexual abuse by a relative. Sean's pediatrician conducted the comprehensive screen mandated by the Medicaid system, which included a behavioral health screen using a standardized tool. The screen identified the need for a more comprehensive mental health assessment, which led to Sean's receiving intensive home-based services and therapeutic mentoring. The Medicaid system's ability to screen for mental health problems and intervene early prevented a likely deterioration in Sean's emotional well-being and behavior and the need for more restrictive placements.

**Note. These are not actual case vignettes; they are representative to illustrate the differences for children as a result of state efforts to strengthen Medicaid for children in child welfare.*

MICHIGAN

QUICK LOOK: Making Medicaid Work for Michigan's Child Welfare Population

- Home and Community-Based Services Waiver
- Incentive payments to providers
- Use of child welfare general revenue as Medicaid match to expand resources
- Presumptive eligibility for children entering care
- Health liaisons and mental health specialists in local child welfare offices
- Timeframes for physical, behavioral and dental health screens through EPSDT for children entering care and use of Pediatric Symptoms Checklist and Ages and Stages Questionnaire
- Broad coverage of home- and community-based services, including evidence-based practices
- Coverage of family and youth peer partners with lived experience
- Coverage of Wraparound approach to service planning
- Red flags and consultation to prescribers for psychotropic medications
- Performance monitoring unique to child welfare population and use of data to show results

Overview of Michigan's Child-Serving Systems

Michigan's child welfare system is administered by the state Department of Human Services (DHS). At any given time, approximately 14,000 children in the state are in foster care. Michigan's Medicaid program is administered by the Department of Community Health (DCH), one of the largest public agencies in Michigan, which also administers public mental health and substance use services. Children's mental health services are directed by the Division of Mental Health Services to Children and Families. DHS and DCH have worked together to improve services for vulnerable children and their families, implementing a number of effective strategies to make Medicaid more functional for children in the child welfare system.

Michigan is the eighth most populous state in the nation, with a population of 9.9 million. The state provides Medicaid coverage for more than 1.7 million residents, nearly half of whom are children. There are nearly 14,000 children in foster care in Michigan.

Background and Collaboration

Michigan's efforts have concentrated on improving the behavioral health services provided through Medicaid for children involved with child welfare. The child welfare system has long recognized that behavioral health problems pose a significant impediment to permanency, safety, and the well-being of children in care. There is a strong history of collaboration between the child welfare and behavioral health systems in the state, and these agencies have strategized jointly about how best to provide effective behavioral health services to this group of children.

"Foster parents were afraid to adopt and birth parents were afraid to reunite based on behavioral health challenges."

Although a partnership was established previously, it was a lawsuit against the child welfare system and a subsequent consent decree that provided the impetus for child welfare and behavioral health to take their collaboration further and implement strategies for improving behavioral health care. The class action lawsuit, filed in federal court in 2006, alleged that the state was failing to move children into stable, permanent homes and was not providing adequate medical, dental, and mental health services. The consent decree resulted in efforts to improve the state's child welfare system, with a particular focus on behavioral health services, which were deemed critical to permanency plans and the ultimate well-being of children in that system.

A key result of the collaboration was the use of a Medicaid Section 1915(c) Home and Community-Based Services (HCBS) Waiver. This waiver allows states to provide long-term care services in home- and community-based settings rather than in institutions. The services provided under this waiver were designed to provide intensive services to children with serious emotional disturbances, including those involved with the child welfare system.

A core interagency operational team, which includes directors from behavioral health, child welfare, and Medicaid, among others, meets every other week to oversee implementation of this partnership. In addition, a policy leadership team that includes higher-level directors from both DHS and DCH meets monthly.

> "The agencies are willing to accommodate each other. They recognize that it will save money down the line if we can intervene quickly with intensive home- and community-based services."

Michigan stakeholders indicated that a successful partnership needs both types of structures – operational and policy level – in tandem to create meaningful change. The leadership team sets policy and ultimately makes decisions; the core team "does the work." Both groups focus on ways to streamline funding and improve access to services. The relationships forged through these structures have resulted in interagency agreements, the application of the HCBS Waiver to the child welfare population, the creation of incentive payments to providers to serve the child welfare population, and additional match to draw down Medicaid funds.

Medicaid Financing and Service Delivery

Physical Health

In 2010, Michigan's Medicaid agency transitioned children in foster care from fee-for-service to managed care under a Medicaid Section 1915(b) Managed Care Waiver, which now covers almost all of the state's children in foster care. The child welfare system was extensively involved in planning for this change to ensure that the new system would incorporate provisions to meet the unique health care needs of these children.

Physical health care is provided by the Medicaid health plans, and each child entering child welfare custody is assigned to a health plan and a primary care practitioner to provide a medical home. If a child entering care is already enrolled in a health plan, the child remains in that health plan unless the plan does not provide services in the community where the child is placed in foster care. As the shift to managed care was implemented, numerous meetings occurred between child welfare and the Medicaid health plans to ensure that the plans had a sound understanding of the needs of this population and how the change would likely affect services for this group. These health plans also are responsible for a basic mental health benefit of 20 outpatient visits. The intent is that the needs of children with mild to moderate mental health problems can be met in this way. Children in need of mental health services beyond these outpatient visits are referred to the Medicaid behavioral health managed care system described below, which is managed by specialty behavioral health organizations.

Behavioral Health

The Medicaid and behavioral health systems are both located within DCH, and its Division of Mental Health Services to Children and Families provides policy and program direction for public mental health services provided to children with emotional disturbances and developmental disabilities and their families. Prepaid Inpatient Health Plans, the HCBS Waiver, and incentive payments are approaches used to provide behavioral health services to children and tailor services to the unique needs of children in child welfare.

Prepaid Inpatient Health Plans – To provide behavioral health services under Medicaid, DCH contracts with Prepaid Inpatient Health Plans (PIHPs), and there are currently 18 PIHPs in the state. The PIHPs are comprised of either a single Community Mental Health Services Program (CMHSP) or an affiliated group of CMHSPs in more rural areas, with one serving as the lead. The CMHSPs deliver behavioral health services throughout the state's 83 counties. The PIHPs are financed through Medicaid on a capitated basis per Medicaid-eligible enrollee. When the managed care waiver is renewed next, the number of PIHPs will likely be consolidated to 10 in an attempt to reduce complexity and bring more uniformity to the system.

Home and Community-Based Services Waiver – The 1915(c) Medicaid waiver for children with serious emotional disturbances (SEDs), referred to as the "SED waiver," was first approved by CMS in 2006. The waiver is used to serve children in local communities, with counties providing general fund match in order to request utilization of a "waiver slot." The SED waiver has also been a primary vehicle for serving children in child welfare with serious behavioral health problems. To implement the waiver for this population, the child welfare system moved funds to behavioral health to provide Medicaid match. With the additional federal Medicaid dollars that are captured, increased resources are available to provide intensive home- and community-based services to children in child welfare who have serious behavioral health challenges. The waiver sits outside of the behavioral health managed care capitation so that the resources are protected for these high-need children. To be eligible for services under the SED waiver, a child must meet the criteria indicating a risk for psychiatric hospitalization without intensive services in the community, and must show substantial impairment on the Child and Adolescent Functional Assessment Scale (CAFAS).

> "Historically, the child welfare system purchased behavioral health assessments and treatment with its own resources. As a result, the use of behavioral health services through the Medicaid managed care system was spotty. The SED waiver has turned this around."

The services and supports under the SED waiver are delivered within the framework and philosophy of a system of care, calling for a broad array of home- and community-based services and supports that are individualized, evidence informed, family driven, youth guided, and culturally and linguistically competent. Joint letters from child welfare and behavioral health were issued establishing systems of care as the desired service delivery approach. Services under the SED waiver are being systematically phased in, beginning with eight large urban counties (which are home to the majority of the child welfare population) and proceeding to include mid-size counties. Smaller counties will be phased in last. To date, more than 36 counties have received technical assistance to begin SED waiver services for children in child welfare, and most are currently providing these services.

The rates for the SED waiver were initially based on a survey of CMHSPs that are delivering services, with an effort to align rates with actual costs. Beginning in 2011, the CMHSPs are also reimbursed for the costs of administering the SED waiver.

Incentive Payments – The SED waiver has served as a way to build trust between child welfare and behavioral health, and to demonstrate that the children's mental health and Medicaid systems can succeed in serving the child welfare population by providing evidence-based practices, tracking and monitoring outcomes, and achieving positive results. Based on this experience, child welfare worked collaboratively with behavioral health to serve children who do not meet the criteria for the level of care provided in a psychiatric hospital setting (i.e., waiver criteria). The result is a second phase of response to the needs of the child welfare population with the creation of incentive payments to make it more feasible for the CMHSPs to serve these children through the Medicaid behavioral health managed care system.

These incentive payments are over and above the capitation rates for Medicaid children and are targeted to children with serious mental health conditions in foster care or those involved with child protective services. Payments are based on "risk categories" and are provided at two levels. If the CMHSP is providing an eligible child with Wraparound or home-based services (outside of the SED waiver), the incentive payment is higher. If a child is not receiving Wraparound or home-based services but is receiving two or more different mental health services in a month, the CMHSP qualifies for a lower incentive payment. The CMHSPs do not receive incentive payments for children receiving services through the SED waiver.

This strategy was implemented in July 2012, and although data are not yet available, there has been positive feedback from the field. Whereas previously the CMHSPs indicated that they could not afford to adequately serve the child welfare population within their capitation rates, the incentive payments have provided a mechanism and a motivation to improve access for this population.

"The CMHPs have received an injection of funding that enables them to serve these high-risk children in child welfare, and the child welfare system is pleased that their children can now access behavioral health services using Medicaid dollars."

Incentive payments are monthly case rate payments for eligible children, paid quarterly. Encounter data are examined, and if the recipient identification matches a child in foster care or child protective services and is in one of the categories described above, then the incentive payment is applied for that child. The payments for the first few months were intentionally higher than those being paid on an ongoing basis, in order to provide resources for the CMHSPs to build capacity to meet the unique needs of the child welfare population. The agencies needed to hire more therapists, in addition to starting new programs and recruiting staff with the specialized skills to serve children involved with child welfare. Incentive payments allow the CMHSPs to provide a broader array of services and supports for children, foster parents, and birth parents.

"By using child welfare general fund dollars as Medicaid match in the behavioral health system, we get much more for our money."

Consequently, the child welfare system is now reducing the purchase of behavioral health services with its own resources. Since the children qualify for the Medicaid entitlement, they can be served through the Medicaid managed care behavioral health system. Child welfare provides its general fund dollars as match that is then enhanced by drawing down federal Medicaid funds.

Approval from CMS is needed for waivers and any changes to the state Medicaid plan. Michigan has been successful in negotiating for these vehicles and breaking through any barriers to getting this accomplished.

Eligibility, Enrollment and Access

In Michigan, children in child welfare have presumptive eligibility for Medicaid. In 2008, eligibility for Medicaid was increased to age 21 for youth whose foster care case closed at the age of 18 or later. In 2012, the state implemented the Young Adult Voluntary Foster Care Program, allowing youth to re-enter foster care and receive a daily stipend and Medicaid coverage, if they meet certain requirements.

To facilitate enrollment and access to physical health services, the child welfare system places health liaison officers within county-based DHS offices. These liaisons are experts in working with the Medicaid health plans and their staff, as well with child welfare staff and foster families. Their role is to ensure that children in child welfare receive the health services they need. When a child enters care, the liaison

officer facilitates enrollment in a health plan, and if the child transitions to a new placement, the liaison officer ensures that health care services continue without disruption.

For behavioral health, federal mental health block grant funds are used to support the initial placement of children's mental health clinicians within child welfare agencies. These clinicians work directly with child welfare staff to identify children who are eligible for services under the SED waiver. The services provided by these "access staff" are essentially screening and assessment and, therefore, are covered under Medicaid on an ongoing basis.

"It is extremely helpful to have mental health staff available on site with the expertise to assess children, determine eligibility for services, and consult with child welfare workers."

Beyond determining eligibility, the clinicians provide consultation, assistance in accessing behavioral health services, and assistance to child welfare staff regarding children in foster care and those involved with child protective services. The presence of the access staff has also cemented relationships at the front line between the child welfare and Medicaid behavioral health systems. All of the initial eight sites for the SED waiver were offered funding for these access positions. Access positions have been added to most of the new sites, some of which had been using existing funds or Medicaid to finance these staff.

Screening and Early Intervention

As Medicaid transitioned to managed care, a subcommittee was formed to specifically address behavioral health care. A particular area of focus was how health plans would screen children in child welfare for behavioral health problems.

Medicaid health plan providers must complete a full medical examination by a physician – which includes a behavioral health component – within 30 days of a child entering foster care. The use of standard screening and assessment tools for behavioral health are required for younger children in Medicaid and recommended for older children for their screens under the EPSDT program. For children in foster care, a validated, normed screening instrument must be used at each scheduled EPSDT well-child visit, and providers must document that medical, behavioral health, and dental screenings have been completed.

Medicaid and behavioral health are exploring the use of validated screening tools particularly for behavioral health issues among children in foster care as part of their well-child visits to primary care practitioners. A recently-finalized policy recommends that providers use the Pediatric Symptoms Checklist for older children in foster care, and Ages and Stages for younger children. The state's Medicaid policy will specify these tools as examples of validated behavioral health screening instruments, and will establish procedures for appropriate assessment and treatment of behavioral health problems. Following the adoption of this policy, meetings will be convened for Medicaid health plans and CMHSPs to provide information and training on referral practices and relationships.

In the Detroit area, a pilot is underway that involves screening children in child welfare in primary care settings, with the addition of a trained mental health clinician in those settings to serve as liaisons, provide training to the primary care practitioners, ensure that assessments are completed, make referrals, and follow up with parents.

Covered Services

A broad array of home- and community-based services and supports is covered in the state Medicaid plan. In addition to traditional treatment services (e.g., individual, group, and

"It's essential that the Medicaid state plan cover a broad range of services and supports so that they're adequately financed and sustainable. It's impossible to meet the needs of children in child welfare without this."

family therapy; medication review and administration; and evaluations), the rich Medicaid benefit includes home-based services, Wraparound, respite, crisis response and stabilization services, Targeted Case Management, treatment planning, family training, family support partners, substance use treatment, and others. Covered services also include evidence-based practices such as Trauma-Focused Cognitive Behavioral Therapy, and Parent Management Training-Oregon Model.

Several services are particularly important for the child welfare population. The intensive in-home services that are covered under the state Medicaid plan play an important role in keeping children in the community and preventing placement disruptions, as well as Wraparound which is also covered under the state Medicaid plan and is a required service for all children served in the SED waiver. Family peer support, provided by individuals with lived experience, is a critical service for children in child welfare and their foster, kinship, and birth families. Youth peer support is also a covered service, and the state is working to implement this service. Mobile crisis teams are another key service available 24 hours a day in some communities.

> "Mobile crisis services have provided an effective way to respond to crises and save placements by de-escalating situations rather than having to remove children in the middle of the night."

Children eligible for the SED waiver can receive additional mental health specialty services and supports that are not in the state plan but covered under the waiver, such as community living services and supports, therapeutic foster care, and family training. They may also receive other services that are not included in the SED waiver, including therapeutic overnight camps, transitional services, and expressive therapeutic activities (e.g., music, art, and recreational therapy).

Child welfare workers, foster parents, kinship care providers, and others have provided positive feedback indicating improved access to behavioral health services and supports, and as a result, less reliance on residential treatment, more stability for children in their foster homes, and increased movement to permanency.

Individualized Service Planning

The SED waiver has demonstrated the importance of the Wraparound approach to service planning and delivery and how this approach is successful in coordinating services and supports for a child and foster family. Wraparound is covered in the state's Medicaid plan so that any child in need can receive this service, but it is provided most frequently to children who are involved in multiple systems and are at risk for out-of-home placement. The Wraparound approach is considered especially relevant for children in child welfare, given their complex needs and the consequent involvement of multiple agencies and caregivers.

The Wraparound process used in Michigan revolves around a child and family team coordinated by a Wraparound facilitator that develops an individualized, tailored service plan to address the unique needs of each child and family. The teams typically include the family (e.g., birth family, foster family, kinship family, or other caregivers), youth (as appropriate), involved providers (e.g., child welfare worker, behavioral health clinician), and informal supports identified by the family. The team, which is unique to each child and family, uses a systematic process to identify both the strengths and needs of the child and family across multiple life domains, strategies for meeting needs, and desired outcomes. The resulting individualized service plan details the services and supports to be provided and includes a crisis and safety plan. As service delivery proceeds, the team monitors progress and revises the service plan as indicated. Extensive Wraparound training and technical assistance is provided to communities to implement the process with fidelity. DCH has a full-time Wraparound training coordinator who organizes and oversees a training program and monitors the fidelity of Wraparound. DCH also contracts with Michigan State

University to evaluate Wraparound and the SED waiver. Both of these contracts are funded with federal mental health block grant dollars.

For children in child welfare, the Wraparound approach offers the opportunity to provide intensive services and supports in all of the areas of need identified through the child and family team process. In doing so, the stability of placements has increased, disruptions in the lives of children have decreased, and the likelihood of achieving permanency goals has improved.

"There have been many testimonials from foster parents who have said that things turned around for them, and they felt so supported by the Wraparound process and the services that were brought to bear."

Using non-Medicaid dollars, the child welfare system also employs a practice model that uses family team meetings for all children when they enter care or change placements. This model includes providers and support persons identified by the family, and a process of engagement, assessment, teaming, and mentoring similar to a Wraparound approach. An individualized plan is created for each child and family through this process. The child welfare worker documents the treatment plan, ensures that services are provided, and monitors progress, similar to the role of the Wraparound facilitator or care coordinator. Use of similar values-based practice approaches creates greater synergy between the child welfare system and the CMHSPs and helps to ensure that all children, not only those with serious behavioral health challenges, receive individualized care.

Medicaid Providers

CMHSPs have their own provider networks to deliver Medicaid services that include a variety of specialists to meet the needs of children in child welfare and other populations. When providers with a particular type of expertise are not available, the agencies may seek out specialty providers that are out of network. Agencies in rural areas with more limited networks may seek out specialty providers more frequently.

The child welfare system also has a network of fair market contracts with private providers that can be used to purchase services for children in child welfare outside of the Medicaid behavioral health system. Often, these providers are used when the child needs more than the 20 mental health outpatient visits allowed by the health plans, but does not meet the criteria for serious emotional disturbances to qualify for the services provided through the CMHSPs. However, these providers are being used less frequently, and Medicaid providers more extensively, as confidence has grown that the CMHSPs can effectively meet the needs of children in child welfare.

"Bringing the SED waiver to so many communities to serve the child population has provided an excellent vehicle for the CMHSPs to learn more about these children and their needs."

CMHSPs receive training on the unique needs of children in child welfare – often from child welfare staff, foster parents, and others with this expertise. The SED waiver and incentive payment vehicles have provided opportunities for such training in an increasing number of communities. Training is provided through the state Wraparound coordinator funded by DCH and through locally organized efforts. Training on mental health services and the SED waiver are also provided to child welfare staff by the CMHSPs. In addition, DCH and DHS hold monthly calls with communities providing services for children in child welfare under the SED waiver, as well as quarterly face-to-face meetings. As a result of the waiver and incentive payments, the child welfare and behavioral health agencies have increased their knowledge about each other's systems, and collaboration between child welfare and behavioral health providers has grown tremendously. Training on serving children involved with child welfare is also provided at the state's annual system of care conference.

Extensive training is provided on evidence-based practices that are covered by Medicaid and essential for the child welfare population. These evidence-based practices are covered by Medicaid when delivered by a certified clinician, using billable service codes such as home-based therapy or individual or family therapy. The state began training clinicians in Trauma-Focused Cognitive Behavioral Therapy in 2008, with the goal that all communities would have clinicians trained in this approach. In addition, a curriculum was developed by the National Child Traumatic Stress Network ("Caring for Children Who Have Experienced Trauma: A Workshop for Resource Parents") to provide information and training related to trauma for foster parents and adoptive parents. The curriculum was adapted by Michigan for use with birth parents to help them understand how to support their children more effectively. The training for clinicians in Trauma-Focused Cognitive Behavioral Therapy and the resource parent training on trauma are both financed with federal mental health block grant funds.

Training in Parent Management Training – Oregon Model has been provided through a partnership between DCH, an affiliate of the Oregon Social Learning Center, and a contract with a CMHSP to oversee a statewide system to train clinicians and ensure fidelity to the model. Clinicians with this expertise are available statewide through the CMHSPs. DCH also hired a coordinator to organize statewide training in the Wraparound approach, ensuring that the model is implemented with fidelity. Michigan also offers a statewide training curriculum on family peer support, and training for peer support providers is delivered through a contract with the state's family organization –the Association for Children's Mental Health, a chapter of the National Federation of Families for Children's Mental Health.

Psychotropic Medication

Michigan has taken a number of steps to address the prescription of psychotropic medications for the child welfare population. A child and adolescent psychiatrist was hired by the child welfare system as a medical consultant at the state level to focus on child welfare issues, including the prescription of psychotropic medications. In 2012, DHS updated its policy to require a standardized written consent form for all prescriptions of psychotropic medication to children in child welfare. In 2012, the state also developed guidelines for psychotropic medications that apply to all Medicaid-enrolled children, as well as an oversight process.

The guidelines for prescribing psychotropic medications include the following 'triggers' that indicate the need for review: a child on four or more medications, a child on two medications in the same class, or a child under five receiving medications. The medical consultant uses these criteria to cross-match the medications prescribed for children in child welfare with the guidelines through a partnership with Medicaid, looking for red flags and outliers. When indicated, the medical consultant follows up with prescribing physicians to review the case and provide consultation. In addition to addressing concerns about medications for individual children, the goal is to identify prescribing trends and to set policy to address any identified issues. The medical consultant also provides training on psychotropic medications to a number of audiences, including foster parents.

Child welfare meets at least monthly with the pharmacy claims division of DCH to review claims for psychotropic medications prescribed to the foster care population. Claims for children in foster care are compared with claims data for the general Medicaid population. The state is in the process of approving an interagency agreement to fund a data specialist at DCH who will be devoted to child welfare work. All informed consent approvals will be routed to this individual, and those falling outside of the prescribing guidelines will be referred to the DHS medical consultant.

A manual describing psychotropic medications and their side effects was purchased by DHS and is being widely disseminated to all CMHSPs, hospitals, residential treatment providers, juvenile justice facilities, and others. Child welfare is also working with the DHS communications department to develop a YouTube tutorial that will be delivered by the medical consultant and disseminated with the manual. This training is supported by child welfare general fund dollars. Interviewees indicated, however, that additional training is needed around medications for primary care physicians, child welfare staff, and foster parents, among others.

Performance and Outcome Measurement

Under the managed care waiver, a reporting system provides encounter data that tracks service utilization, and includes a marker to identify children in child welfare. For behavioral health, the CAFAS is used to determine eligibility for services through the Medicaid behavioral health system, as well as to monitor progress. The CAFAS was converted into an electronic system to make it easier for the CMHSPs to collect and report the data.

> "Evaluation results have been extremely helpful in demonstrating to the leadership team and other stakeholders that the investment in home- and community-based services produces positive outcomes, providing a strong foundation for moving to the next phase of broader implementation."

For children served under the separate SED waiver, data are collected relative to a set of indicators, and a functional assessment is built into the system using CAFAS scores. Preliminary data suggest significant success in serving children involved with child welfare. For example, results demonstrate success in keeping children in the community, reducing the use of residential treatment, and significantly improving functioning based on changes in CAFAS scores. CAFAS data are also available for children receiving services through the incentive payment part of the system and will be part of the evaluation for this initiative.

Almost all of the children served under the SED waiver have histories of stays in residential treatment, psychiatric hospitals, or emergency shelters. Data show that at six months, upwards of 97 percent of children enrolled in the SED waiver were able to be maintained in the community with home- and community-based services and supports. As compared with the previous system of child welfare providing services through contracts without the ability to demonstrate outcomes, the system now shows policy makers and the legislature what they are spending and the results they are achieving, particularly in comparison to residential treatment and hospital care.

Next Steps for Michigan

Looking to the future, interviewees indicated areas that require further attention. First, better strategies are needed to serve children who have more moderate needs and do not meet the criteria for having a serious emotional disturbance. Often, the 20-visit mental health outpatient benefit provided through the Medicaid health plans is not sufficient to meet the needs of these children, but they are not at a severity level that would make them eligible for Medicaid services through the CMHSPs.

Eliminating any remaining duplication between the child welfare and Medicaid behavioral health systems is another potential area for improvement. According to interviewees, continuing strategies are needed to hold the CMHSPs accountable for providing services to the child welfare population and for child welfare workers to decrease their use of separate contract providers. Increased trust of CMHSPs among child welfare workers is needed before they will completely give up the option to use their own providers. Although trust is gradually increasing, specific additional strategies to address this need consideration.

Another identified gap is the difficulty in obtaining Medicaid services for parents. If children are in foster care, their parents lose their Medicaid coverage if they do not qualify on their own, leaving them ineligible for Medicaid-covered services even if the child welfare system is working toward reunification. As a result, their treatment needs often go unmet, stifling a full recovery for the family.

In addition, efforts are needed to incorporate a greater focus on behavioral health in appointments for physical health care. Interviewees indicated that a more holistic approach would be ideal, but that primary care practitioners often do not feel that this is within their purview or area of expertise.

As implementation of the ACA proceeds, the state has given some preliminary thought to whether PIHPs may qualify as health homes, but no decisions have yet been made.

Advice to Other States

- Cover a broad array of services and supports under the state Medicaid plan to ensure that they are adequately financed and sustainable.
- Create an administrative structure at the state level, with both a core operational team and a policy leadership team across child welfare, Medicaid, behavioral health, and other key agencies.
- Demonstrate with data that the Medicaid behavioral health system can deliver the services needed by the child welfare population and achieve good outcomes.
- Incorporate behavioral health staff at the front line to help child welfare staff assess the need for behavioral health intervention, determine appropriate services, and link with providers.
- Incorporate child welfare liaison staff with expertise in Medicaid to facilitate enrollment when a child enters foster care, ensure that children are linked with primary care providers, and provide feedback to policy makers about needed improvements in access to physical health and behavioral health services.
- Ensure that the partnership includes state and local stakeholders, both of which are needed to implement strategies to improve services, particularly in a county-run system.
- Include evidence-based practices that are relevant for the child welfare population in the array of covered services and supports.
- Monitor Medicaid claims data against the foster care population and measure service utilization and outcomes for this group of children.

> "They are 'our' kids, and we must take steps together to make sure they're being served. We're thankful for what child welfare, behavioral health, and Medicaid have already accomplished and for the willingness to continue working collaboratively."

Conclusion

Michigan's efforts to make Medicaid work better for children in the child welfare system have paid off, particularly in increasing access to a broad array of home- and community-based services. These high-need children are the most expensive to serve, and they consume the bulk of time and financial resources of the child welfare, Medicaid, and behavioral health systems. If they cannot access home- and community-based behavioral health services, they frequently change placements and require more costly residential care. Interviewees reported that the key to success is to share the responsibility for serving these children and to be open to working together to meet their needs.

ILLUSTRATING THE IMPORTANCE OF MICHIGAN'S EFFORTS: Jacob and Jeremy*

At 12, Jacob was removed from his father's home due to neglect and was placed with an aunt in another town. Jacob began using drugs and skipping school. His aunt talked to her child welfare case worker about getting Jacob substance abuse counseling and also thought that a male adult mentor would be good for him. However, traditional Medicaid did not cover substance abuse services or therapeutic mentors, and the child welfare system's budget had been cut, making access to these services through child welfare also difficult. Jacob became increasingly angry and aggressive toward his aunt, and after threatening her with a knife, was held at the juvenile detention center. While there, Jacob attempted suicide. He was hospitalized in an adolescent psychiatric unit for a week, placed on psychotropic medications, and discharged to a residential treatment center after his aunt refused to take him back without community-based services. Jacob remained in the residential facility for nine months, and was then discharged to a foster home. The one-year cost of his detention, hospitalization, medications and residential stay totaled $67,900, $48,000 of which was paid for by Medicaid.

Contrast Jacob's story with that of Jeremy, also removed from home at age 12 and placed with a relative, and having a similar history of substance use, skipping school, anger, aggression, and alternating threats to kill his grandmother or himself. Jeremy, however, was enrolled in a Medicaid waiver program allowing access to substance abuse treatment, therapeutic mentoring, and a Wraparound process that provided him with a care coordinator and his grandmother with a family partner to provide peer support. Most importantly, they were both involved in a structured, strengths-based Wraparound process to find community-based approaches and solutions to the problems Jeremy was experiencing. The waiver services Jeremy and his grandmother received over the course of a year – therapeutic mentoring, substance abuse counseling, and Trauma-Focused Cognitive Behavioral Therapy for Jeremy, and family peer support for his grandmother; as well as care coordination, and use of a small amount of flexible funds for a boxing gym membership paid for by child welfare, totaled $21,740 in costs to Medicaid. Jeremy remains in the community with his grandmother.

**Note. These are not actual case vignettes; they are representative to illustrate the differences for children as a result of state efforts to strengthen Medicaid for children in child welfare.*

NEW JERSEY

QUICK LOOK: Making Medicaid Work for New Jersey's Child Welfare Population

- Customized child behavioral health carve-out using blended funds, Medicaid as administrative single payer system and DCF with management oversight
- Coverage of intensive care coordination at low ratios using high-quality Wraparound and care management organizations for children with complex behavioral health needs
- Payment for family and youth peer support using Medicaid administrative dollars
- Coverage of broad array of home- and community-based services using the Rehab Services Option
- Maximization of Medicaid by using child welfare, behavioral health and Medicaid dollars to expand federal match
- Health units in child welfare financed with Medicaid administrative dollars
- Requirement for designated care coordinators in Medicaid HMOs as liaisons to child welfare
- Payment for behavioral health clinical consultation to local child welfare offices
- Enhanced Medicaid rate for physical and behavioral screens within 30 days of placement
- Training of Medicaid providers in evidence-based practices and in the child welfare population
- Tracking data indicators specific to the child welfare population
- Tracking and review of psychotropic medications through data sharing between child welfare and Medicaid

Overview of New Jersey's Child-Serving Systems

New Jersey's child welfare services are administered by the Department of Children and Families (DCF) through its Division of Child Protection and Permanency. Children's behavioral health services are also administered by DCF, with its Division of Children's System of Care taking the lead.

The state's Medicaid program is housed within the Department of Human Services (DHS), Division of Medical Assistance and Health Services. DCF and DHS have been collaborating for over a decade to improve the delivery of physical health care for children in child welfare and to build a children's behavioral health system, which operates essentially as a child population behavioral health carve-out. Although Medicaid dollars for children's behavioral health services are managed by DCF and are in the DCF budget, the state Medicaid agency acts as the single payer administratively for all children enrolled in the child behavioral health system, for Medicaid- and non-Medicaid-eligible children alike.

New Jersey is the 11th most populous state in the United States with a population estimated at nearly 9 million in 2012. Approximately 1.2 million individuals are enrolled in Medicaid and the Children's Health Insurance Program, close to half of whom are children. There are approximately 7,800 children in foster care in the state.

Background and Collaboration

Strategies for meeting the health and behavioral health care needs of children in child welfare have their roots in several converging factors in the state. One catalyst for change was a lawsuit brought in 1999 on behalf of children in foster care by Children's Rights, a nonprofit agency. The class action lawsuit was aimed at ensuring improved outcomes for children in out-of-home placement by improving the state's child welfare system. The lawsuit resulted in a settlement agreement in 2003 (which was later modified in 2006) that mandated sweeping reforms in the child welfare system. In 2007, a new cabinet-level department was created (DCF) that raised child welfare issues to the top level of state government, and an executive team was created to implement the needed reforms. The reforms have involved adopting a new case practice model to

"The settlement agreement is not an end and further represents only part of what must be a larger plan to deliver on the promise of safety, well-being, and permanency for New Jersey's children."

incorporate best practices for serving the child welfare population, rigorous training for staff and supervisors, and an emphasis on outcomes informed by the use of a Statewide Automated Child Welfare Information System (SACWIS).

Improvements in physical and behavioral health care were a significant focus of the child welfare reforms. Collaboration among the Medicaid, child welfare, and behavioral health agencies was instrumental in achieving the goals of these reforms.

Physical health services were addressed first. Around 2004, with Medicaid's support, the child welfare agency sought to enroll children in foster care into the Health Maintenance Organizations (HMOs) under contract with Medicaid, rather than keeping them in a fee-for-service Medicaid system. Coordination of care was improved by assigning a care manager in the health plan to be responsible for linking and working with the child's care provider.

Following the creation of DCF in 2006, child welfare sought to bring the health care case management of children in foster care to a new level and partnered with the University of Medicine and Dentistry of New Jersey's School of Nursing to develop and implement child health units within child welfare to improve care coordination for children.

"High-quality health care services have been significant in improving outcomes for children in child welfare, as well as reducing caseloads and improving overall practice."

Efforts to implement systems of care for children's behavioral health took a big leap forward in 2000 with the development of a plan for a statewide system of care. The plan involved a sequential rollout in each county or in groups of smaller counties comprising a service area. Implementation was a five- to six-year process, with the first three counties rolled out in 2001 and the last three counties in 2006.

There was a great deal of high-level and political support for this initiative (first referred to as the Children's System of Care Initiative), including from the governor's office. It created much excitement in the state, particularly among families, who were instrumental in developing and generating support for the initiative. Family advocacy is credited as a critical factor in the adoption of the system of care approach throughout the state, and this approach is now firmly established in state policy and has spanned multiple administrations.

"The child welfare lawsuit and settlement really didn't focus on behavioral health, but there was a parallel process to develop systems of care and we're all connected now."

The parallel process in the behavioral health system ultimately connected with the child welfare reforms. Ongoing collaboration and a strong working relationship are the basis for the success that has been achieved.

"Strong working relationships among child welfare, behavioral health, and Medicaid allow us to be more flexible (than a rigid policy document) and allow us to respond to a changing environment."

Medicaid has been a strong partner in the statewide implementation of systems of care. The agency serves as the single payer for the child behavioral health delivery system, utilizing funds pooled across mental health, child welfare, and Medicaid to draw down additional federal Medicaid match.

Although there is no formal structure at the state level, ongoing meetings among partners are used to discuss issues, solve problems, and create new policies where indicated. At the county level, Children's

Interagency Coordinating Councils provide a structure for collaboration, joint planning, and problem solving.

Medicaid Financing and Service Delivery

All children in foster care who are receiving New Jersey Medicaid are enrolled in one of the four HMOs that are under contract with Medicaid. These plans are funded with a capitation rate, and they, in turn, pay negotiated rates to a network of providers who provide comprehensive physical and dental health services to children in child welfare.

For behavioral health services, New Jersey identified services previously supported solely with state dollars that could be incorporated into the state Medicaid plan. The state then covered these services under the Rehabilitation Services Option (Rehab Option), allowing them to capture federal funding for these services. New Jersey used the "freed" state dollars as seed money to build the infrastructure for new community-based services across the state. In the first year of its system of care reform, New Jersey financed its Medicaid match by combining $167 million in existing state general fund dollars being spent on children with serious emotional disturbances through child welfare and behavioral health (including $117 million that was previously spent on residential care) with $39 million in new funds authorized for children with serious emotional disorders in the 2001 governor's budget. Currently, a combination of child welfare, behavioral health, and Medicaid funds support behavioral health services, including those provided to children in child welfare.

> "Our system of care was built by blending funds across systems to maximize federal Medicaid funding. This was the key to redirecting existing funds to develop community-based services and reducing residential treatment."

In October 2012, after about a year of negotiations, CMS approved New Jersey's application for a Medicaid Section 1115 Demonstration Waiver, referred to as the "Comprehensive Medicaid Waiver." This waiver will redesign the state's Medicaid program to provide greater flexibility and improve care coordination, financing, and the ability to provide services in home- and community-based settings. The Comprehensive Waiver will combine the existing Medicaid and Children's Health Insurance Program (CHIP) and the state's four previous Medicaid Section 1915(c) Home and Community-Based Waivers, and will require that approximately 98 percent of Medicaid beneficiaries enroll in managed care. When implemented fully, all children, including those with developmental disabilities and substance use disorders, will receive their behavioral health services through the children's behavioral health system (child behavioral health carve out).

> "We were very persuasive with CMS and convinced them that without this flexibility there is an 'institutional bias' and that children would be placed in costly residential settings."

The Comprehensive Waiver preserves the integrity of the child behavioral health carve-out. It also will allow the state to consider a child at risk for institutional-level care as a "family of one," waiving parental/guardian income that would otherwise render the child ineligible for Medicaid, enabling access to home and community services for these children. By using Medicaid dollars to serve these children in home- and community-based settings, rather than in institutional-level care, Medicaid is expected to save money.

Through the Comprehensive Waiver, three new behavioral health services will be added to the benefit package: youth support and development (a service somewhat similar to mentoring), services for youth in transition to adulthood (ages 16 – 21), and non-medical transportation that is part of a child and family's individualized service plan. Similar to the approach used to build the system of care, previous state-only

funding for home- and community-based services will be utilized as Medicaid match so that federal Medicaid dollars can be drawn down to expand service delivery. This strategy makes sense for expanding services for populations of children, such as those in foster care, who tend to be Medicaid-eligible and for financing services that can be covered by Medicaid, rather than relying only on state general revenue funds.

Physical Health

Each child enrolled in one of the Medicaid-contracted HMOs has a primary care practitioner (PCP), typically a pediatrician. Selection of a health plan and PCP is based on the child's need and caregiver's preferences. To the extent possible, if a child is already enrolled in an HMO and has an existing relationship with a PCP, continuity of care is encouraged by keeping the child with the same plan and provider.

Physical health services have been improved dramatically through investments in a child health unit (CHU)-based model of care coordination in partnership with the University of Medicine and Dentistry of New Jersey's School of Nursing. CHUs are co-located in each of the 47 child welfare offices across the state, where they work collaboratively with case workers, foster parents, and other caregivers to ensure children's health care needs are being met. CHUs partner with HMO care managers to ensure timely access to care for children and youth, particularly for children requiring specialty care. CHU staffing includes baccalaureate prepared nurses and staff assistants. The CHUs are staffed to ensure that there is one nurse for every 50 children in out-of-home placement. Regional nurse administrators supervise the local units for each region.

> "Nurses on the ground coordinate with health workers using a basic health care road map to make sure that health care takes place."

Every child entering foster care is assigned to a nurse who serves as a health care case manager and resource person. The nurses work in the trenches with child welfare caseworkers, helping to address key aspects of well-being for children in out-of-home placement by ensuring children receive timely well-child visits, immunizations, and dental care and ensuring each child has an updated health plan that is reviewed with the caregiver and youth as appropriate. Nurses visit children in out-of-home placement within two weeks of entering care and thereafter at regular intervals. These visits are often conducted with the child welfare caseworker, and are used to assess health care needs, provide developmentally-appropriate anticipatory guidance, and review the child's health care plan with the caregiver. Since the health units were established, outcomes have significantly improved, with 100 percent of children entering foster care receiving a pre-placement assessment, 87 percent receiving a comprehensive medical exam within the first 30 days, 82 percent receiving dental services, and 96 percent having up-to-date immunizations.

Behavioral Health

> "The system is not a child welfare, mental health, Medicaid, or juvenile justice initiative, but one that crosses systems."

The children's behavioral health system in New Jersey is essentially a Medicaid carve-out that has been customized for children. It serves all children and adolescents with serious behavioral health challenges statewide and their families. New Jersey has created a single, integrated system of behavioral health care across child-serving systems, which has drawn on multiple financing streams, including Medicaid, behavioral health general revenue, and child welfare dollars to create a single payer system. The goal is to serve youth with emotional and/or behavioral health needs and their families by providing a broad array of home- and community-based

services that are guided by system of care values including strengths-based, individualized, efficacious and culturally competent services and partnerships with families and youth.

DCF provides children and families with a virtual single point of contact that registers, tracks, and coordinates behavioral health care for children by contracting with a commercial managed behavioral health care organization called PerformCare. This organization functions as an administrative services organization, which New Jersey calls a Contracted Systems Administrator (CSA). PerformCare manages referrals, data, financing, and other system-level functions.

At the local level, nonprofit care management organizations (CMOs) under contract with DCF provide intensive care management using a Wraparound model for youth with complex needs. DCF also contracts with locally-based nonprofit Family Support Organizations (FSOs) that provide peer support to families involved with the CMOs as well as advocacy, policy and advisory activities, community education, and warm lines. FSOs are funded through a combination of state general revenue and Medicaid administrative case management dollars. These organizations also house Youth Partnership initiatives that provide opportunities for youth to offer peer support, participate in social marketing and strategic communications activities, and assume leadership roles in systems of care. CMOs in partnership with FSOs function as a more customized approach to coordinating care for children with the most serious behavioral health challenges, many of whom are involved with the child welfare system.

The CMOs serve as sole-focus care management agencies primarily funded by Medicaid, and Medicaid funds for this purpose are managed by and sit within the budget of DCF. Approximately 10 percent of the funding for CMOs comes from state-only administrative dollars. Services and supports for children served by the system of care who are not Medicaid eligible are currently financed with state funds. However, as noted, this will change to a large degree as the Comprehensive Waiver is implemented and Medicaid can be billed for their services based on the premise that the costs of institutional care will be avoided by providing home- and community-based services within the system of care. It is estimated that about 35 percent of children in CMOs are involved with child welfare, though this varies by county. The average 35 percent representation is much larger than the approximate 3 percent representation of child welfare-involved children in the overall Medicaid child population.

At the county level, each CMO has a relationship with the child welfare office in its respective area. Typically, the child welfare office designates a lead person with behavioral health expertise who connects with the area CMO. This person fulfills a liaison role including coordination and problem solving functions. Coordination is also supported by regular meetings between child welfare area directors and CMO executive directors, in addition to the coordination activities between the nurses in the CHUs and the CMOs.

> "Relationships between the CMOs and area child welfare offices are continually improving. It's helpful to have a child welfare person who is the 'go to' person for behavioral health and works directly with the CMO."

The children's behavioral health system also provides a newer generation model of 24-hour mobile response and stabilization services (MRSS) for *all* youth with behavioral health needs. This model provides both 72-hour crisis intervention and ongoing eight-week stabilization services, enabling a team to work with the child, family/caregiver, teacher, and others in the home and community to link the child to appropriate services. In each of the last five years, this service has prevented placement disruption (i.e., has kept the child in his/her living situation) for 96 percent of children served. MRSS

is a particularly important service for children in child welfare who often change placements due to behavioral health crises.

Eligibility, Enrollment, and Access

New Jersey does not have presumptive eligibility for Medicaid for children in foster care. DCF handles eligibility determination and works to enroll children expeditiously in Medicaid. Children who are not eligible for federal Medicaid due to financial or citizenship status are enrolled in a parallel state-funded (non-FFP) Medicaid program. Children may be eligible for Medicaid up to age 21.

Currently, Medicaid-eligible children who need basic behavioral health services (e.g., brief outpatient services) may access these services through community mental health centers and other providers who participate in HMO networks. Some children also may access basic services through providers contracted by the child welfare system. Children who need more intensive behavioral health services are referred to PerformCare (i.e., to the behavioral health carve out). To facilitate access, child welfare has a separate phone number for PerformCare that connects with a team that specializes in the child welfare population and is trained extensively in the unique needs of this group. The state is currently in the process of consolidating behavioral health services so that all children will access behavioral health care through the behavioral health carve-out.

In addition to PerformCare's specialized child welfare team, access is enhanced by each CMO employing a clinical consultant who is available to provide behavioral health consultation to nurses and other child welfare workers in each county's child welfare office. In addition to case-specific consultation, an ancillary benefit of the clinical consultants is that they are well positioned to serve as liaisons. Their close connection with child welfare allows them to improve communication, identify problems, and address issues collaboratively with their child welfare partners.

> "The clinical consultant is the 'go-to' person on mental health issues and is a great resource to child welfare staff."

Screening and Early Intervention

Children entering foster care are required to have a physical health exam within 30 days of placement, which is paid for by Medicaid at an enhanced rate negotiated by Medicaid and child welfare. Mental health screening is also required for children in out-of-home placement and must be completed within the first 30 days of placement. CHU nurses and case workers are responsible for ensuring that children receive ongoing screening and that those who are identified with a suspected mental health need receive an assessment and follow-up care.

Regular screenings during well-child visits, mandated by Medicaid's EPSDT benefit, are performed by the child's PCP within the assigned HMO. A behavioral health component is required as a part of the screens, and although no specific tool is required, PCPs must specify the tools they use for this purpose.

The state behavioral health system of care utilizes common assessment tools to evaluate children with suspected behavioral health treatment needs. The tools used in New Jersey are a version of the CANS. The CANS is also used by CMOs for service planning and outcome measurement.

Covered Services

The state's behavioral health carve-out for children has a broad benefit package that includes a range of traditional clinical services as well as nontraditional services and supports. To achieve this breadth, the state expanded the services covered by Medicaid under the Rehabilitation Services Option to include: assessment, mobile response and stabilization services, therapeutic group home care, treatment

homes/therapeutic foster care, intensive care management, Wraparound process, intensive in-community services, and behavioral assistance. Family peer support provided through the FSOs is financed through Medicaid administrative dollars. Intensive in-community services are psychotherapy services provided in the child's home and/or community. Under a plan developed with the intensive in-community therapist, a behavioral assistant can work with the child and family to modify specific behaviors.

Through the new Comprehensive Services Waiver, youth support and development, services for youth in transition to adulthood (ages 16 – 21), and non-medical transportation that is part of a child's individualized service plan will be covered as well. Some specific evidence-based practices are covered under Medicaid, including Multisystemic Therapy and Functional Family Therapy, each of which is available in key areas of the state. DCF has financed training for clinicians in various evidence-based treatment including Cognitive Behavioral Therapy, Trauma-Focused Cognitive Behavioral Therapy, Parent Child Interaction Therapy, Brief Strategic Family Therapy and others. The most commonly selected training by counties has been Trauma-Focused Cognitive Behavioral Therapy. As noted, Medicaid also covers intensive care coordination using high quality Wraparound through the CMOs, a model that has a growing evidence base; the state helps to finance this model using Targeted Case Management.

This array of home- and community-based services has allowed the state to decrease the length of stay in residential treatment centers by 25 percent, reduce expenditures for psychiatric hospitalization, and nearly eliminate out-of-state treatment placements. Of youth accessing mobile response and stabilization services, 96 percent are able to remain in their homes rather than being placed in inpatient or other out-of-home treatment settings. The number of youth in custody who are in juvenile detention settings awaiting placement has also been reduced significantly. In addition, New Jersey has the 47th lowest youth suicide rate in the country, suggesting that increased access to behavioral health screens and earlier intervention may be having an impact.

Services and supports that are part of the individualized service plan, but are not covered by Medicaid are financed with state-only dollars (e.g., tutoring, camp, dance classes, karate lessons). Therapeutic mentoring and transportation were previously the most utilized services funded with state-only dollars. However, they are now covered under Medicaid, allowing the state to further maximize available funds by increasing the federal contribution.

Specialized services needed by the child welfare population, such as treatment related to sexual abuse and attachment issues, are also available. Contracts with providers from both the behavioral health and child welfare systems include language that requires particular services and specifies standards and outcomes.

Birth parents are also able to access needed behavioral health services, including treatment for substance use. Child welfare conducts needs assessments, and covers the costs of services if a parent is not covered by Medicaid or private insurance.

Individualized Service Planning

New Jersey's children's behavioral health system utilizes the Wraparound approach to developing, implementing, and coordinating individualized service plans. CMOs use child and family teams created for each family to develop these plans, which are required to be strength- based and culturally relevant. They also must address safety and permanency issues for children referred to CMOs who are involved with the child welfare and juvenile justice systems. CMOs are required to hold a child and family team meeting within 30 days of the initiation of services. Many CMOs use tools developed by the National Wraparound Initiative to ensure fidelity to the model.

CMOs employ care managers who serve as Wraparound facilitators, carry small caseloads, and receive close supervision and support from clinical supervisors. New Jersey's CMOs have formed a professional association, which certifies Wraparound care coordinators.

Care managers and child and family teams are assisted by FSO family support coordinators who provide peer support for families involved with CMOs. Family peer support is financed through Medicaid administrative claims. Community resource development specialists located at CMOs also support the individualized service delivery approach by identifying and developing community supports and natural helpers to augment treatment services.

For children also served by the child welfare system, birth parents, foster parents (referred to as 'resource parents' in New Jersey), and kinship families are included in a family team meeting that shares many similarities with the Wraparound child and family team approach and is instrumental in guiding the planning process for the family. Nurses from the child welfare health units attend the initial team meetings when indicated and may participate in subsequent meetings as needed. Efforts are underway across the state to join these meetings into one when a child is being served by both systems rather than having parallel processes in the child welfare and behavioral health systems.

> "We're in the process of marrying the two systems, and there are pilots in the state to demonstrate this. Ultimately, we want to cut down and have only one service plan for a child and family."

Medicaid Providers

Each of the four Medicaid managed care plans (HMOs) has a provider network that includes a broad array of specialty health providers. For example, if a child in the child welfare system needs a pediatric cardiologist, the HMO must procure providers to deliver that specialty care.

Developing providers skilled in trauma-informed care is a work-in-progress in the state. There are specific requirements for trauma-informed services in residential treatment programs for children with histories of trauma, including evidence-based practices. Current efforts are exploring how to build trauma-informed services within both the child welfare and behavioral health systems.

There are several vehicles in the state for training Medicaid providers on the unique needs of the child welfare population. The New Jersey chapter of the American Academy of Pediatrics conducts outreach to physician practices on child abuse and neglect prevention and provides education about the child welfare system and how to recognize suspected abuse and neglect. DCF supports a Child Welfare Training Academy that focuses primarily on providing training to child welfare professionals, but in recent years, training has also been made available to providers and others in the community who might benefit. In addition to training related to the specific roles of child welfare staff, specialized training in such topics as child sexual abuse, working with lesbian and gay youth, working with gang-involved youth, and others may be relevant to the provider community and help them to develop the specialized skills needed to work with children in child welfare.

The behavioral health system provides training and technical assistance through the University of Medicine and Dentistry of New Jersey's Behavioral Health Research and Training Institute. This structure is financed through a contract with the university, and allows considerable flexibility in using funds to meet the training and technical assistance needs of behavioral health providers. Some of the training offered by the Institute is specific to children in child welfare and their needs, and a particular emphasis of the training is on child and family team practice. The Behavioral Health Research and Training Institute and the Child Welfare Training Academy have not been well connected in the past, but efforts are underway to better coordinate their work.

Psychotropic Medication

DCF developed a psychotropic medication policy several years ago in collaboration with many stakeholders that took part in a psychotropic medication advisory council. This policy has helped to monitor the use of psychotropic medications for children receiving services from DCF.

More recently, New Jersey became a part of a six-state national quality collaborative, coordinated by the Center for Health Care Strategies, to reduce the inappropriate use of psychotropic medications in the foster care population. The state created a team comprised of Medicaid, child welfare, and behavioral health to explore potential next steps to advance its efforts to monitor the use of psychotropic medications.

Performance and Outcome Measurement

The Office of Performance Management and Accountability (PMA) in DCF is instrumental in performance and outcome measurement for both the children's behavioral health and child welfare systems. PMA assesses service delivery, along with the needs, strengths, and experiences of families involved with DCF.

DCF also assesses performance and outcomes for both behavioral health and child welfare through contract monitoring. Outcomes-based contracts are used that require information about a number of key outcome indicators, some particularly relevant to the child welfare population such as stability of children and families, well-being, and permanency.

The class action settlement requires regular reports with data on specific benchmarks, including physical and behavioral health services data. For example, data are collected on how many children receive pre-placement medical assessments, comprehensive medical exams, exams in compliance with EPSDT guidelines, semi-annual dental checks, and immunizations. For behavioral health services, reports are generated on mental health assessments for children with suspected mental health needs and the extent to which they receive timely and appropriate follow-up and treatment.

SafeMeasures is a continuous quality improvement system that is used to meet reporting needs, as well as to produce data dashboards accessible to child welfare workers in the field. Information from SafeMeasures feeds into New Jersey Spirit, which is the child welfare data system. The CANS is used to derive outcome data for children receiving behavioral health services through the CMOs.

Next Steps for New Jersey

The state will continue to promote trauma-informed care by increasing the knowledge and skills of child welfare, health, and behavioral health providers, and exploring evidence-based practices. Its efforts to ensure safe and appropriate use of psychotropic medications among children will also continue.

The new Comprehensive Medicaid Waiver will impact services for children in child welfare, particularly for those with dual diagnoses of substance use disorders and pervasive developmental disabilities. Planning is underway to implement the reforms made possible by the waiver.

DCF developed a strategic plan for 2012 – 2014 that provides a framework for the next steps to improve the quality and outcomes of service delivery. The strategic priorities include:

- **Seamless System of Care** – To provide ease of access to care for children, youth and families;
- **Performance Management and Accountability** – To ensure the integrity and quality of DCF's system of care;

- **Partnerships** – To collaborate with stakeholders and community partners to improve outcomes for New Jersey children, youth and families;
- **Communication** – To enhance the effectiveness of communication with employees, partners, the media, and the general public; and
- **Organizational Development** – To continually examine and prepare the organization structurally, in alignment with the mission and strategic plan.

Another priority is to better engage biological families in services. Since many children are ultimately reunified with their families, the state seeks to better position parents to understand their child's health needs and help them to develop the skills needed when the child returns home.

"We are strong proponents of the behavioral health and child welfare systems sitting structurally in the same department. That has allowed us to work together closely to connect these systems. Medicaid dollars also sit in the department and the executive management team can determine how Medicaid is used for our populations."

Planning for implementation of the ACA is in the early stages, and the implications for Medicaid, behavioral health, and child welfare are being explored.

Advice to Other States

- Consider an organizational structure that places behavioral health and child welfare within the same department. In New Jersey, this has been a highly effective approach to connecting those systems.
- Shift the management of Medicaid behavioral health dollars from the Medicaid agency to behavioral health. This allows for financing strategies to be designed to specifically meet the behavioral health needs of children enrolled in Medicaid, including the child welfare population.
- Create child health units in child welfare. All indications are that the model has led to improved access to health, dental, and behavioral health care for children in child welfare.
- Emphasize family involvement in both policy and services. New Jersey has adopted a family-centered approach to services, created Family Support Organizations in each locality that are funded by Medicaid administrative dollars, provided family peer support services through the FSOs, and included families on policy and advisory groups.
- Invest in staff training and development to move the system to a strength-based, individualized, family-centered practice model, to reduce inappropriate placements, and to provide home- and community-based services.
- Emphasize cross-agency collaboration. This has played an essential role in New Jersey in bringing the voices of all of the partner systems to the table to think through challenges and design strategies and plans.

"We're doing a full court press on providing comprehensive medical, dental, and mental health services to children in child welfare. It has been a success story for our state."

ILLUSTRATING THE IMPORTANCE OF NEW JERSEY'S EFFORTS: Natalie and Angela*

Natalie was placed in foster care for neglect at age nine. She suffered from asthma and, to her new foster mother, seemed very anxious. Her foster mother took her to her family pediatrician, and he changed her asthma medication and prescribed anti-anxiety medication. After Natalie was with them for close to a year and doing fairly well, her foster family moved away from the state, and Natalie was placed with another family. She also had a new child welfare case worker. Somehow, Natalie's case file with the notes about her health issues and medications did not make the transition with her. Her new foster mother took her to a new pediatrician, who continued asthma medication and put her on an anti-depressant, noting that she seemed remarkably withdrawn. Natalie began to gain weight on the new medication, which, in turn, aggravated her asthma. She also began to stay in her room for long periods of time. Her foster mother called the pediatrician, who increased the dosage on her anti-depressant. On a weekend not long after, Natalie had a severe asthma attack and her foster parent took her to the emergency room. The emergency room staff treated her asthma and also observed that Natalie seemed to be making no sense, her speech was incoherent and her thoughts racing. They placed her on an anti-psychotic medication. Around this time, Natalie's foster family had a child of their own and told the state that they could no longer care for Natalie.

Contrast Natalie's experience with that of Angela, also removed from home around age nine and placed with a foster family. Angela, who had asthma and attention deficit hyperactivity disorder, also experienced several foster care placements in the three years she was in foster care. However, the pediatricians she saw all participated in the Medicaid HMO networks and had participated in trainings provided by the child welfare system. Her child welfare workers, who were charged with providing consent for psychotropic medications, had access to medical expertise through the health units in the local child welfare offices. In addition, Angela had an electronic health record, noting her health issues and medications, which the health unit periodically ran against the Medicaid claims data system to ensure that there were no additional medications being prescribed about which the child welfare workers were not informed. In particular, the system would flag certain medications, such as anti-psychotics, for review by a consulting child psychiatrist. As a result, there was much better oversight and management of the medications that Angela received to ensure she received only what was appropriate. Her mental health status did not deteriorate, and she ultimately was adopted by her foster family.

**Note. These are not actual case vignettes; they are representative to illustrate the differences for children as a result of state efforts to strengthen Medicaid for children in child welfare.*

Lessons Learned

Cross-State Lessons

Lessons learned from the experiences of these four states provide valuable guidance to other states in their efforts to 'make Medicaid work' for children in child welfare. These lessons fall within several broad categories – including, understanding the unique needs of the child welfare population, covering a broad range of services and supports, and creating financial incentives to provide high quality care – each of which is highlighted below.

Understand the Unique Needs of Children and Families Involved with Child Welfare

All of the states began their work with the premise that children in child welfare have unique needs that require customized responses in delivering both physical and behavioral health care. These children comprise a vulnerable and high-risk population with a high prevalence of physical, behavioral, and developmental problems. Their Medicaid service use, particularly of behavioral health care and psychotropic medications, mirrors or exceeds that of children on Supplemental Security Income (SSI). Their histories include trauma from abuse and neglect, separation from their homes and families, and often multiple out-of-home placements entailing changes in schools, caregivers, friends, and routines. Historically, many of the needs of these children have not been met, the services that they receive have been expensive, and outcomes have been poor.

"One of the most effective things we've done was to create a matrix showing the unique needs of children in child welfare and developing a protocol to guide Medicaid providers to respond to each one."

In addition to the child welfare system, multiple child-serving systems touch the lives of these children – Medicaid, behavioral health, primary health care, substance use, education, early childhood, juvenile justice, systems serving transition-age youth, and others. Interviewees stressed that all of these systems must be attuned to the needs, nuances, and journeys of children in child welfare and must participate in designing and implementing strategies to respond. All of these states recognized the critical importance of behavioral health care especially for children in child welfare and have devoted much of their efforts to improving the financing and quality of Medicaid behavioral health services and supports.

Recognize the Importance of Relationships and Collaboration

Uniformly, interviewees emphasized that cross-agency relationships are critical and that strategies must be grounded in an acknowledgement of shared responsibility for children in child welfare along with receptiveness to working together to meet their needs. Although partnerships between child welfare and Medicaid are fundamentally key, the efforts described here nearly always involve the behavioral health agency and, in many cases, other child-serving agencies as well. In addition, the states profiled indicated that while collaboration at the state level is essential, collaborative relationships at the local level among system leaders and front line staff are also critical for policies and procedures to be implemented.

"It's all about relationships!"

The states have built a variety of interagency structures as vehicles for joint strategy development and problem solving. These include high-level policy structures such as a policy leadership team in Michigan and the Children's Behavioral Health Initiative Executive Committee in Massachusetts. Interagency operational-level structures have also been created, such as the core leadership team in Michigan, as well as local structures, such as the local coordinating councils in Arizona and the interagency children's system of care councils in New Jersey.

Create Multiple Strategies

In these four states, strategies typically were not designed and implemented as a complete package. Rather, some were developed as needs were identified and were implemented sequentially over a period of years. Others were implemented as part of a larger system redesign that involved significant systemic changes, such as the Children's Behavioral Health Initiative in Massachusetts, the system reforms in Arizona and Michigan (each of which resulted from class action lawsuits involving Medicaid), and the children's system of care initiative in New Jersey. It is important to note that, while a class action lawsuit can provide a powerful impetus for change, the impetus can also result from reviewing practice and outcomes for children in child welfare and proactively developing strategies for improving services and supports. In New Jersey, child welfare reforms and a children's system of care initiative were implemented through cross-system collaboration.

> "It's hard to identify the most effective strategy. It's a combination – one can't work without the others."

In addition, these states used multiple strategies, rather than relying on just a few approaches. In fact, each of the states had at least some strategies in all of the areas explored such as screening, service coverage, individualized care, and financing approaches.

Incorporate a Robust Medicaid Benefit

All of the states expanded Medicaid coverage to include a broad array of services and supports, moving beyond traditional services to significantly enrich the Medicaid benefit. Intensive in-home services, intensive care management, Wraparound service planning, family and youth peer support, mobile crisis services, respite care, family training, therapeutic mentoring, therapeutic foster care, supported housing, and supported education and employment are among the services that were added to their state Medicaid plans or are provided under a Medicaid Home and Community-Based Services Waiver.

In addition, the states cover many specific evidence-based practices, either under their own service codes or under existing codes. Examples that are particularly important for the child welfare population include: Trauma-Focused Cognitive Behavioral Therapy, Parent Management Training-Oregon Model, Multisystemic Therapy, and Multidimensional Treatment Foster Care. Providers with expertise in areas essential for children in child welfare are required to be included in Medicaid provider networks, such as clinicians with skills in the areas of trauma, adoption, sexual abuse, and attachment disorders. A specialty providers' initiative in Arizona mandates the inclusion of these providers, and in Michigan, training is provided statewide to ensure that skilled clinicians are available to provide trauma-informed services in each service area. In New Jersey, a university-based institute provides training related to child and family team practice.

> "It's essential that the Medicaid state plan cover a broad range of services and supports so that they're adequately financed and sustainable. It's impossible to meet the needs of children in child welfare without this."

Adopt an Individualized Approach to Services Using the Wraparound Process

An individualized approach is the cornerstone of planning and delivering behavioral health services under Medicaid in all of these states, who each use high-fidelity Wraparound as defined by the National Wraparound Initiative. A child and family team facilitated by a care coordinator is created for each child and family and includes the family and youth, child welfare worker, behavioral health provider, other involved services providers, and other support persons identified by the family. This team creates and implements a comprehensive, individualized service plan that guides service delivery. In two of the states, Massachusetts and New Jersey, the Wraparound approach is combined with intensive care

coordination at low ratios (e.g., one care coordinator for eight to ten children and families), billable through Targeted Case Management, to ensure the appropriate intensity of care management for children in child welfare with serious and complex issues. Wraparound is the practice approach used both by New Jersey's and Massachusetts' care management entities that serve high-need children.

In the states studied, services included in the child and family team's plan of care are considered authorized for purposes of Medicaid. For example, in Arizona, the teams are empowered to determine medical necessity, and the service plans they develop are automatically authorized. Only a few designated services, typically those that are restrictive and expensive, may require prior authorization outside of the teams, such as residential treatment. Interviewees stressed that the Wraparound process is powerful for children and families in child welfare and plays a critical role in coordinating care.

> "Foster parents have said that things turned around for them, and they felt so supported by the Wraparound process and the services that were brought to bear."

Create Financing Vehicles to Maximize Resources and Flexibility

These states have taken advantage of various Medicaid options and provisions to implement their strategies; some of these options were already in place in the state's Medicaid system but not sufficiently customized for children in child welfare. The Medicaid 1115 Research and Demonstration Project Waiver has provided flexibility for both Massachusetts and Arizona. A Medicaid 1915(c) Home and Community-Based Services Waiver in Michigan has been used as a primary vehicle for serving children in child welfare who have serious emotional disturbances. In some cases, the child welfare agency has transferred funds to provide Medicaid match, enabling the state to draw down additional federal Medicaid dollars, thereby maximizing the resources available for services. The Medicaid Rehabilitation Services Option has been used to support home- and community-based services, including evidence-informed practices, as in New Jersey. Targeted Case Management has provided a vehicle for intensive care coordination for children with intensive needs, as in New Jersey and Massachusetts. In Arizona, Medicaid contracts with a single health plan that provides all physical and dental health services to the child welfare population.

> "The providers have received an injection of funding that enables them to serve these high-risk children in child welfare, and the child welfare system is pleased that their children can now access behavioral health services using Medicaid dollars."

The states have also implemented incentive payments and risk-adjusted rates to ensure adequate resources to serve children with high needs in the child welfare population. For example, Michigan implemented incentive payments to its community mental health service providers for children in foster care that are over and above standard Medicaid capitation rates, in order to provide both a mechanism and motivation to meet their needs. In Arizona, risk adjusted rates provide significantly higher capitation rates for children in child welfare.

Understand the Mandates, Goals, and Cultures of Partner Agencies

Collaboration is difficult without a basis of understanding among partner agencies, including how they view their missions and goals and the cultures in which they function. Child welfare, Medicaid, and behavioral health agencies come to the table with their respective roles and mandates in mind, and thus, a broad shift in thinking is often needed to accomplish real change. Partners also need to understand the constraints and pressures that are experienced by each, such as increasing caseloads for

> "It is a constant dance for everyone to be comfortable with community-based alternatives to residential treatment and to increase utilization of these services."

child welfare workers or deficits in Medicaid. As one interviewee noted, "Child welfare, Medicaid, and behavioral health should learn more about the functions, mandates, and operation of each system and establish a vehicle for bringing the systems together in conversations regarding what is needed to make them work together in a more collaborative and cost-effective way."

Ensure Solid Implementation and Monitoring of New Strategies

In reflecting on their experiences, interviewees underscored the importance of focusing not only on designing policies, plans, strategies, and practice protocols, but also on the quality of the implementation of these strategies. There is often a difference between policies designed at the state level and how they are implemented in the field. Accordingly, it is critical to have specific, measurable criteria, such as expectations of the number of children to be served, the number of care managers hired, size of caseloads, and training required, as well as close monitoring of expectations. Monitoring is essential to track performance, assess progress, identify problems, and improve implementation.

> "Clear, formal expectations, supported by training, are needed to ensure that providers throughout the system are prepared for successful implementation; and routine monitoring should be used to make sure strategies are implemented with 'fidelity' to the intention."

Interviewees also stressed the importance of tracking service utilization and outcomes for the child welfare population. Examples include monitoring penetration rates for the child welfare population in the Medicaid system, the types of services they are receiving, use of psychotropic medication, expenditures, and outcomes. Less than positive results provide valuable information for quality improvement, while positive results can be instrumental in demonstrating to policy makers improvements in services, cost savings, and the impact of home- and community-based services for children in child welfare. In Michigan, data have shown that the Medicaid behavioral health system, for example, can, in fact, deliver the services needed by the child welfare population and achieve good outcomes.

Implement Sustainability Strategies for Each Provision

> "Without the buy-in and commitment of high-level leaders, the whole building will fall down."

A caution expressed by many interviewees is the potential difficulty in sustaining the strategies put into place to make Medicaid more responsive to the needs of children in general, and children in child welfare in particular. This challenge was attributed primarily to changes in executive leadership that result in changing priorities, new directions, and lack of commitment to the work started under previous administrations. Since newly appointed leaders were not a part of the initial efforts, they may not have the information needed to continue to allocate staff and resources or may have different priorities. New leaders may not be familiar with the needs of the child welfare population and with the approaches implemented. It was emphasized that for each approach adopted, consideration should be given at the outset as to how it will be formalized so that the both the strategies and the commitment to the needs of children in child welfare will be maintained over the long term.

A two-pronged approach was recommended. First, strategies should be "institutionalized" in policy, contracts, financing, regulations, and other vehicles to ensure continuity. Changes must be systemic and incorporated into the system, rather than pilots or actions without mechanisms to keep them in place over time. A capacity for ongoing orientation and training related to policy, system, and practice changes is needed both for quality control and to build a broad base of support. In addition, intentional strategies are needed to provide new decision makers with information and data to garner their support.

Fiscal crises and budget cuts also have an impact on care for children in child welfare and for the services and supports that are financed by Medicaid. In some cases, there is an influx of children entering foster care, which is attributed to stressors related to the economy. With funding cuts and increased demand, some children and families may find it more difficult to obtain services, caseloads may increase, and financing strategies that have been implemented may be in jeopardy. It was noted, however, that fiscal crises can also present opportunities for child welfare, Medicaid, and other child-serving agencies to invest resources more wisely in cost-effective approaches. National mandates and opportunities, such as those associated with the Affordable Care Act, the Fostering Connections to Success and Improving Adoptions Act, and the Child and Family Services Implementation and Innovation Act, provide a platform for child welfare and Medicaid systems to work together to improve the quality and cost of physical and behavioral health care for children in child welfare.

Moving Forward

All of these states recognize that they are "works in progress." What distinguishes them is that they have created long-standing collaborative approaches among the child welfare, Medicaid, and behavioral health systems, maintaining respect for the mandates and pressures facing each system and developing common ground. Each of these states has made a commitment to continue this work to refine their strategies and undertake efforts to tackle the needed next steps they identified.

"They are *our* kids, and we must take steps together to make sure they're being served. We're thankful for what child welfare, behavioral health, and Medicaid have already accomplished and for the willingness to continue working collaboratively."

As states move more fully into implementation of health reform, the experiences and lessons from these four states may help to inform such innovations as health homes, patient-centered medical homes, the use of home- and community-based options like the 1915(i) provision, benefit designs, managed care requirements, and other key features to ensure that the needs of children in child welfare are appropriately addressed.

[1] S. Pires, K. Grimes, K. Allen, T. Gilmer, and R. Mahadevan. Spring 2013 (forthcoming). *Faces of Medicaid: Examining Children's Behavioral Health Services Use and Expenditures*. Center for Health Care Strategies.
[2] For more information, visit the National Wraparound Initiative website at: http://www.nwi.pdx.edu/

Additional Child Welfare Resources

The Center for Health Care Strategies' (CHCS) Child Health Quality portfolio includes a substantial focus on improving access to and quality of health care for children in child welfare. CHCS works with Medicaid, child welfare, and behavioral health stakeholders on such issues as: (1) addressing psychotropic medication use among children in foster care, (2) improving Medicaid managed care for children in child welfare, and (3) addressing the behavioral health needs of children in child welfare. Visit www.chcs.org for more information on CHCS' child welfare-related initiatives and resources.

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Medi-Cal Explained FACT SHEET

Medi-Cal and Behavioral Health Services

Authors: Margaret Tatar, Principal, and Richard Chambers, Principal, Health Management Associates

Introduction

MENTAL HEALTH AND SUBSTANCE USE DISORDERS are among the most common health conditions faced by people in California.[1] Complicating these challenges, individuals with co-occurring behavioral health and physical health conditions experience highly fragmented systems of care, contributing to poor health outcomes and elevated levels of unmet treatment needs.[2] The Medi-Cal program pays for a significant portion of mental health treatment in California, and promoting better access to services for beneficiaries through the integration of behavioral and physical health is a key goal for the program.

Medi-Cal covers a wide range of services for the treatment of mental health and substance use disorder (SUD) conditions, which are delivered through Medi-Cal managed care plans (MMCPs), county mental health plans (MHPs), and separate county and state programs. In a recent analysis, the California Department of Health Care Services (DHCS) found that just 5% of Medi-Cal beneficiaries accounted for 51% of total Medi-Cal expenditures, and that most of those had at least one behavioral health condition.[3] The FY 2018-19 state budget projects that Medi-Cal will spend more than $3 billion for mental health and SUD services.[4] In response to health and budgetary pressures, DHCS has been pursuing behavioral health integration strategies to enhance coordination and collaboration among the care delivery systems.

Overview of Medi-Cal Mental Health Benefits

Since 1995, Medi-Cal specialty mental health services have been provided under a federal Medicaid Section 1915(b) freedom-of-choice waiver titled "Medi-Cal Specialty Mental Health Services." Until 2014, this waiver required beneficiaries to access almost all mental health services through MHPs. MMCPs were only responsible for ensuring that their primary care providers offered mental health services that were within the normal scope of their practice (e.g., brief therapy, writing prescriptions). County mental health agencies were responsible for providing or arranging for mental health services for Medi-Cal beneficiaries within the Medi-Cal fee-for-service (FFS) system.

As managed care plans have become the dominant mode of service delivery across the Medi-Cal program, their role in the provision of mental health services has also increased. Beginning in 2014, DHCS required MMCPs to provide mental health services to members with mild to moderate impairment of mental, emotional, or behavioral functioning. The 18% of Medi-Cal beneficiaries still in the FFS system continue to access some care for mild to moderate impairments with providers in the community who

Table 1. Medi-Cal Mental Health Delivery System

	Medi-Cal Managed Care Plan (MMCP)	Medi-Cal Fee-for-Service (FFS)	County Mental Health Plan (MHP) Outpatient Services	County Mental Health Plan (MHP) Inpatient Services
Services	**Responsible for arranging and paying for mild to moderate mental health services when provided by licensed mental health care professionals (as defined in the Medi-Cal provider bulletin) acting within the scope of their license:** ■ Individual and group mental health evaluation and treatment (psychotherapy) ■ Psychological testing when clinically indicated to evaluate a mental health condition ■ Outpatient services for the purposes of monitoring medication therapy ■ Outpatient laboratory, medications, supplies, and supplements ■ Psychiatric consultation	■ Beneficiaries needing mild to moderate behavioral health care are eligible for the same services as for managed care members ■ Services accessed through FFS Medi-Cal private behavioral health providers, community clinics, and other local and county clinics	**Beneficiaries receive outpatient specialty mental health services through county MHPs, including:** ■ Mental health services: ● Assessment ● Plan development ● Therapy ● Rehabilitation ■ Medication support services ■ Day treatment intensive ■ Day rehabilitation ■ Crisis residential ■ Adult crisis residential ■ Crisis intervention ■ Crisis stabilization ■ Targeted case management ■ Intensive care coordination, home-based service, and therapeutic foster care for children and youth under the age of 21	**Beneficiaries receive inpatient mental health care services through county MHPs, including:** ■ Acute psychiatric inpatient hospital services ■ Psychiatric health facility services ■ Psychiatric inpatient hospital professional services if the beneficiary is in a FFS hospital

Source: "Mental Health Services Division (MHSD)," California Department of Health Care Services, last modified October 10, 2018, www.dhcs.ca.gov/services/Pages/MentalHealthPrograms-Svcs.aspx.

participate in the FFS Medi-Cal program. Providers for these Medi-Cal mental health services may include private practitioners, community health clinics, and county mental health clinics. MHPs continue to be responsible for the delivery of care for patients with specialty mental health issues that result in impairment in functioning, and for emergency and in-patient behavioral health services for all Medi-Cal beneficiaries.

Table 1 outlines the outpatient and inpatient mental health services Medi-Cal provides, and the systems through which these services are delivered.[5]

This dual delivery system for mental health services requires coordination and communication among the MMCPs and MHPs. Accordingly, DHCS requires the MHP in each county and its corresponding MMCP(s) to have a memorandum of understanding delineating care coordination and information exchange requirements. When health plan members are identified as needing access to specialty or behavioral health services, the health plan care coordination staff must work with county MHP staff to ensure that needed services are accessed.

Drug Medi-Cal

In California, counties operate SUD treatment through Drug Medi-Cal, which has traditionally provided a limited set of services. Access for both Medi-Cal managed care and FFS beneficiaries seeking care has been a challenge, given the limited benefits and low Medi-Cal FFS reimbursement rates, which limit the number of providers willing to serve beneficiaries. Another challenge of the Drug Medi-Cal program has been connecting the physical and mental health care systems serving the same beneficiaries. Ideally, Medi-Cal managed care members would receive assistance from their health plan care coordination staff and primary care physicians, who help them gain access to necessary treatment services by guiding them to their county's care system. However, Medi-Cal beneficiaries seeking both SUD and mental health services

have historically faced challenges in accessing and using services.

With a goal of making significant improvements to the Drug Medi-Cal program, in 2015 DHCS received the nation's first Medicaid Section 1115 demonstration waiver to implement an SUD demonstration program. The Drug Medi-Cal Organized Delivery System (DMC-ODS) pilot program requires that Medi-Cal beneficiaries in need of SUD services be assessed according to nationally recognized criteria and referred for treatment according to their individual needs. DMC-ODS includes access to a broader range of services, including:[6]

- Early intervention (overseen through the new managed system of care)
- Outpatient services
- Intensive outpatient services
- Short-term residential services (up to 90 days with no facility bed limit)
- Withdrawal management
- Recovery services
- Case management
- Physician consultation
- Additional medication-assisted treatment (MAT) (county option to provide)
- Partial hospitalization (county option)
- Recovery residences (county option)

Participation by counties in DMC-ODS is voluntary, and 40 of California's 58 counties are participating. As of January 1, 2019, 24 of those 40 counties had begun providing services under the pilot, representing more than 75% of the Medi-Cal population statewide. When the remaining counties that have submitted implementation plans begin services, nearly 97% of Medi-Cal enrollees will have access to a DMC-ODS pilot program. Counties that choose to participate operate as a managed care plan for SUD treatment, setting their own internal payment rates for each covered service and contracting with providers to deliver care.[7]

Looking Ahead

DHCS has undertaken several initiatives over the past few years to improve access to and quality of Medi-Cal behavioral health services, using new strategies to increase coordination and integration of those services with medical services. These include:

- **Coordinated Care Initiative for Dual Eligibles (2014):** The Cal MediConnect demonstration program has been implemented in seven counties to coordinate and integrate Medi-Cal acute and long-term services and supports (LTSS) with Medicare benefits for dual-eligible beneficiaries within a single managed care plan. The goal is to improve the delivery of Medi-Cal and Medicare behavioral health services by the plan through coordination with the county MHPs. The program is approved through 2019, and DHCS has submitted a request to the Centers for Medicare & Medicaid Services (CMS) to extend it.[8]
- **Whole Person Care Pilots (2016):** Authorized under the state's Section 1115 Medi-Cal waiver (through 2020), these pilots have been implemented in 25 counties and one city. The overarching goals of the pilot programs are the coordination of physical health, behavioral health, and social services in a patient-centered manner and a more efficient and effective use of resources. The pilots provide support at the county/local level to integrate care for Medi-Cal beneficiaries who are high users of multiple systems and experience poor health outcomes (e.g., frequent ED users, homeless individuals).[9]
- **Health Homes Program (2018):** Authorized under the ACA and state law, this program provides enhanced care coordination services for those with complex physical health and behavioral health care needs. The program will be implemented in 14 counties between July 2018 and January 2020. The MMCPs in those counties will work in partnership with community-based care management entities.[10]

The delivery of Medi-Cal mental health and SUD services are currently defined within two waivers. The Medicaid Section 1915(b) freedom-of-choice waiver ("Medi-Cal Specialty Mental Health Services") and the Medicaid Section 1115 demonstration waiver ("Medi-Cal 2020") expire on June 30, 2020, and December 31, 2020, respectively. DHCS completed extensive stakeholder outreach on the future of both waivers in 2018.

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A CLOSER LOOK

An Overview of Systems of Care in Child Welfare✧

"Changing practice in the field is one of the most difficult tasks of child welfare agencies, and also the cornerstone to any successful efforts that we make." (Ohl, 2003)

OVERVIEW

In recent years, systems of care principles have been increasingly adopted because of their potential to support efforts to improve child welfare and other human service systems in ways that lead to increased safety, permanency, and well-being for children, adolescents, and their families. However, while the systems of care approach has become more widespread, a clear understanding of what defines a system of care and how it operates has not kept pace. As the systems of care approach gains wider acceptance, the Children's Bureau has committed considerable resources to assessing its impact and to understanding how this approach might be best applied in public child welfare settings.

In any given year, approximately 500,000 children are involved in the child welfare system nationwide. Children and their families face a variety of issues including neglect, physical and sexual abuse, domestic violence, health and mental health challenges, and educational and vocational challenges (Children's Bureau, 2008). Also, children, youth, and families of color are often disproportionately represented in the child welfare system.

More than any other human service system, child welfare is charged with ensuring the overall safety of the children it serves. Federal mandates such as the Child Abuse Prevention and Treatment Act, Indian

Improving Child Welfare Outcomes Through Systems of Care

In 2003, the Children's Bureau funded nine demonstration grants to test the efficacy of a systems of care approach to improving outcomes for children and families involved in the child welfare system and to address policy, practice, and cross-system collaboration issues raised by the Child and Family Services Reviews. Specifically, this initiative is designed to promote infrastructure change and strengthen the capacity of human service agencies to support families involved in public child welfare through a set of six guiding principles:

1. Interagency collaboration;
2. Individualized, strengths-based care;
3. Cultural and linguistic competence;
4. Child, youth, and family involvement;
5. Community-based approaches; and
6. Accountability.

A Closer Look is a series of short reports that spotlight issues addressed by public child welfare agencies and their partners in implementing systems of care approaches to improve services and outcomes for children and families. These reports draw on the experiences of nine communities participating in the Children's Bureau's Improving Child Welfare Outcomes Through Systems of Care demonstration initiative, and summarize their challenges, promising practices, and lessons learned. Each issue of *A Closer Look* provides information that communities nationwide can use in planning, implementing, and evaluating effective child welfare driven systems of care, and is intended as a tool for administrators and policy-makers leading systems change initiatives.

✧ The National Technical Assistance and Evaluation Center wishes to thank the following individuals for their contributions to this resource: Patrick Melius, Sharri Black, and Maryrose McCarthy.

Child Welfare Act, Multi-Ethnic Placement Act, Foster Care Independence Act of 1999 (The Chafee Program), Adoption and Safe Families Act, and Promoting Safe and Stable Families Amendments of 2001 dictate what public child welfare systems must do, often despite severely limited resources. To address these challenges, child welfare administrations must be innovative in accessing and leveraging the resources of other child- and family-serving systems, families, and communities.

In addition, the Child and Family Services Reviews, implemented in 2000 as the mandated monitoring system, are an important impetus for State child welfare systems to improve outcomes for children, youth, and families. The review process has identified significant gaps between the ideals and the realities of current child welfare systems across the country (Children's Bureau, 2004).

Because systemic change is at the core of the Child and Family Services Review process, each State's Program Improvement Plan (designed to address review findings) must not only address frontline practices but also must propose other systemic changes, including changes in training, supervision, administration, funding, and governance. Such changes are challenging and their success depends on the capacity of the leadership, management, frontline workforce, providers in the service array, families, and the community at large to initiate and maintain processes that transform day-to-day practice, policy development, and standards of accountability (Ackerman & Ackerman, 2001). The systems of care approach integrates these mandates and system change processes by offering a comprehensive and principle-based framework to promote and sustain continual positive change within child welfare and partner agencies.

Defining Systems of Care

The systems of care literature and the lessons learned by the nine federally funded States and tribes and the 18 participating communities of the Children's Bureau's Improving Child Welfare Outcomes Through Systems of Care demonstration initiative contribute to a foundational definition of systems of care in the child welfare context.

A review of the systems of care literature reveals that the definition of a system of care has evolved over the past two decades, based primarily on work in children's mental health. Hodges, Ferreira, Israel, and Mazza (2007) present a definition that reflects current systems of care components:

> A system of care incorporates a broad, flexible array of services and supports for a defined population(s) that is organized into a coordinated network, integrates service planning and service coordination and management across multiple levels, is culturally and linguistically competent, builds meaningful partnerships with families and youth at service delivery, management, and policy levels, and has supportive management and policy infrastructure. (p. 9)

Similar to Hodges et al., other definitions that developed out of efforts to address failures to meet the mental health needs of children emphasize service planning and coordination. Overall, the definitions identify essential elements of a system of care: value-based, population-focused, strengths-based, family-driven, integrative and coordinated, individualized, culturally competent, community-oriented, and flexible with a broad array of appropriate services and natural supports.

Current definitions emphasize an ideal set of conditions for how a fully implemented system of care operates. In light of the challenges faced in child welfare, the developmental aspects of a system of care and its role in effecting change must be recognized. Given the current mandates for system change in child welfare, these elements are critical for administrators seeking to understand and develop systems of care.

Based on the experiences of the grant communities, systems of care in child welfare would be defined as a *principle-guided approach to developing and sustaining systemic changes that result in improved outcomes for children and families*.

Principle-guided—Child welfare driven systems of care are guided by six core principles, which are the essential elements of the framework for achieving a balanced and effective child and family service system. The six principles are interagency collaboration, individualized strengths-based care, cultural competence, child and family involvement, community-based services, and accountability. While definitions of these principles vary in the literature, they represent the foundation for creating a more effective child welfare system based on change and ongoing evolution. The goal of a principle-guided change process is to operationalize each principle throughout the child welfare system, with each principle embodied in, and guiding the work of, administration policies and practices (DeCarolis, Southern, & Blake, 2007).

Continuous Change Process—Guided by core principles, a system of care systematically promotes and manages system change efforts, including building a system of care and sustaining operation of the system. Similar to building or remodeling a house, constructing systems of care requires considerable advance work, such as planning, identifying and gathering essential resources and partners, and continuous quality improvement, to create a shared and compelling vision of desired outcomes. The building process requires diverse skills such as leadership, marketing, strategic planning, and collaboration. Once built, a system of care operates in a larger context of changing political, legislative, fiscal, and service issues. To maintain effectiveness, a system of care must continuously adapt to the environment. With the guiding principles and infrastructure as constants, the systems of care approach provides a framework for building and maintaining organizational and community capacity to successfully navigate the complexities of systems change.

Developmental Systems Change—In a stage-based developmental process, the systemic change necessary to achieve improved outcomes for children and their families takes considerable time to mature. Often supported by Federal, State, or private foundation funding, the initial stages of establishing a system of care may take 3–6 years. Building the infrastructure of a system of care requires time to craft a shared vision, develop a theory of change, develop strategic and action plans, establish governance structures, and foster the trust necessary to formalize and sustain long-term commitments. As the system develops, policy, practice, financing, and leadership will require adjustments, and a deepening commitment to the principles and goals will be necessary. In theory, a system of care moves from the infrastructure-building phase to sustainability with a gradual change in level of effort, as shown in figure 1. In reality (figure 2), phases often overlap and cycle between building/rebuilding and sustaining the system. Shifts in effort may be driven by a variety of forces such as changes in population, election cycles, funding, or leadership. This cyclical change process calls for revisiting earlier commitments and decisions at frequent intervals during the building stages and at regular intervals in sustaining operations. Because systems of care continuously monitor and adapt to changes in the environment, agencies adopting this approach operate

Figure 1

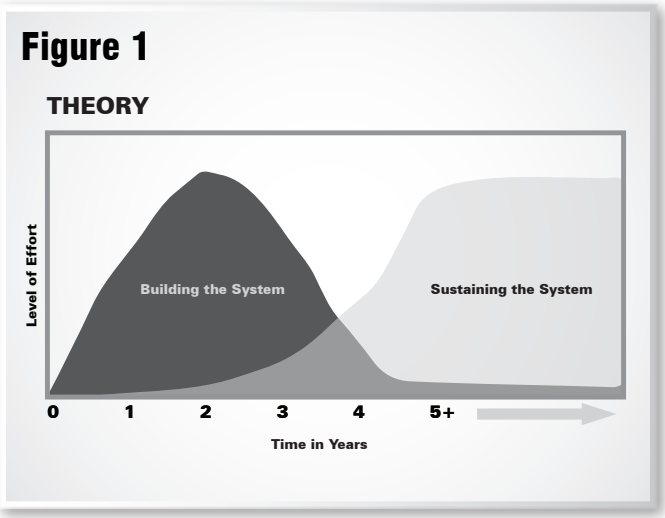
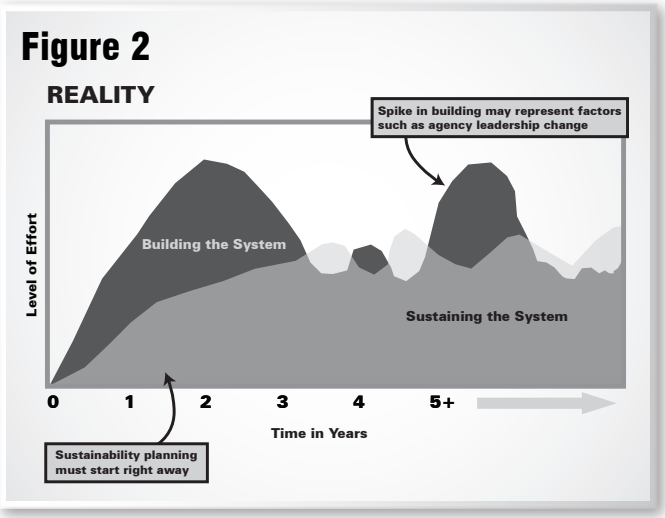


Figure 2



as learning organizations characterized by purposeful and insightful agility (Senge, 1990).

Results Focused—Promoting systemic change in child welfare is meaningless unless the changes lead to better outcomes for children and families. Given the fiscal constraints and mandates that affect child welfare systems, decision-makers must be able to reliably determine if changes initiated through a systems of care approach are enabling better outcomes. In addition, they need to understand the impact of systemic change in relation to Federal and State mandates. Because systems of care often require collaboration with other departments, agencies, or organizations, their respective objectives for demonstrating results or impacts must also be addressed. Therefore, a well-designed quality assurance process through which timely data are collected, shared with stakeholders, and used to make adjustments is a vital element of any systemic change process.

Systems of Care in Child Welfare

A fully developed system of care would include all major human service systems, rather than focus on a single system. However, in building an integrated system, the needs that characterize each system and the unique mandates that affect them must be considered throughout the change process. Much of the current literature and research on systems of care reflect a focus on mental health issues. Contemporary examples of systems of care, outcomes research, and even the national network of experts and consultants are largely drawn from the mental health field. The Children's Bureau's Improving Child Welfare Outcomes Through Systems of Care demonstration initiative was designed specifically to focus on the challenges of serving children in the child welfare system while integrating with systems of care efforts in other human service agencies. This 5-year effort has enhanced understanding of how a systems of care approach can be shaped for the child welfare field.

Preliminary findings suggest that to be most effective in child welfare, especially as a framework for change, systems of care must be tailored and based on an in-depth understanding of the mandates and challenges child welfare administrations face and the diverse needs of children, youth, and families. Child welfare has a culture and history that are unique. The traditional psychosocial or ecological approach to understanding and meeting the needs of children; an emphasis on ensuring child safety, permanency, and well-being; and a history of collaborative work with other agencies are hallmarks of child welfare. However high staff turnover requires continuous orientation processes and the often adversarial relationships and power differentials between families and frontline staff make trust and strengths-based approaches difficult to implement. Responding to the unique needs of overrepresented and culturally diverse populations, and negative visibility in the wake of tragedies, also are factors in adapting the systems of care approach to child welfare.

Implementation of the Child and Family Services Reviews represents a unique opportunity for following the systems of care approach. The Child and Family Services Review process increasingly has focused not only on frontline practices but also on systemic change (Ohl, 2008). While changes in frontline practice may lead to improvements for a small, targeted group, unless those changes are adopted and supported by policies and processes throughout the organization and service array, they will remain at best pilot or demonstration projects. Conversely, policy changes without complementary change in frontline services or practices are unlikely to lead to improved safety, permanency, or well-being for children. Child and Family Services Reviews have placed increased demand on States to engage in a structural and comprehensive change process designed to address these challenges.

Commonalities Between Systems of Care and the Child and Family Services Review Process

Systems of Care Guiding Principles	Child and Family Services Reviews Practice Principles
■ Family and youth involvement	■ Family-centered practice—Strengthen and empower families to protect and nurture their children
■ Community-based child- and family-centered services	■ Community-based practice—Support the needs of children within the context of their families and communities
■ Individualized, strengths-based care ■ Cultural and linguistic competence	■ Individualizing services—Tailor interventions to meet specific needs of children and families served
■ Interagency collaboration ■ Accountability	■ Strengthening parental capacity—Promote parent strengths and self-esteem by emphasizing partnership with service providers

The core principles implemented through the Improving Child Welfare Outcomes Through Systems of Care demonstration initiative correspond closely to those underlying the Child and Family Services Reviews (Pires, 2008). Despite slight differences in terminology, the complementary principles represent a sound set of child welfare focused guidelines that can facilitate a systems of care driven change process.

Any systems change effort should promote an integrated and orderly process of change. However, like many organizations, child welfare systems can be prone to environmental stressors. Perhaps the most challenging in child welfare is the loss of a child's life while in care. The failure to protect a child is devastating, highly public, and often results in dramatic, abrupt, and often reactionary changes in the system. Line and senior staff alike often are removed from or resign their positions, policies may change, and scrutiny and oversight increase. Programs that are largely effective may be jettisoned for less effective approaches that appear to be safer. When such changes happen abruptly, they frequently are not integrated well throughout the system (Bertelli, 2004). Because the systems of care framework for change is guided by core principles that promote accountability and transparency, child welfare administrations and their partner human service agencies have greater potential to respond to crises in a purposeful and insightful manner.

Challenges and Strategies: The Experience of Child Welfare Driven Systems of Care Grant Communities

The grant communities and the National Technical Assistance and Evaluation Center supported by the Children's Bureau's Improving Child Welfare Outcomes Through Systems of Care demonstration initiative serve as a national learning laboratory for understanding how systems of care can be used effectively to build a stronger child welfare system. This demonstration initiative provides resources to understand how a principle-guided process promotes change at both the systems and individual outcome levels (safety, permanency, and well-being). Since the initiative was

launched in 2003, the Children's Bureau and State child welfare administrations have shown growing interest in building systems of care to organize and implement State Program Improvement Plans. The grant communities also have provided details about the challenges and potential rewards of establishing a systems of care framework to achieve systems change and improve child and family outcomes.

Data from the national and local evaluations reveal that the communities are changing how they conduct the work of promoting permanency, safety, and well-being of children, youth, and families. The grant communities report that the work is challenging and change typically does not proceed evenly. The experiences of the grant communities illuminate the challenges of operationalizing each principle and demonstrate their unique and innovative approaches to building and sustaining systems of care.

Operationalizing each principle means that within each level of child welfare and partner agencies, tangible, observable indicators of the principle exist. For example, promoting family involvement is exemplified in the Kansas Family Centered System of Care by the active and valued participation of family leaders on statewide quality improvement councils, as well as the public-private partnership between the State child welfare system and the statewide Kansas Family Advisory Network. Similarly, in addressing interagency collaboration, the Colorado grantee community was instrumental in shaping and gaining acceptance for Colorado House Bill 1451, promoting interagency collaboration between State human service agencies and the involvement of family members and community stakeholders in designing and implementing service systems.

In addressing some of the major challenges of child welfare, grant communities have used systems of care to respond in ways that promote safety and build on collaborative processes. New York and Oregon both faced the challenge of a child's death. In both cases, the structure and processes guided by systems of care principles helped stabilize the agency and provided some consistency in the midst of tumult and unpredictability. In one instance, changes in policies and frontline procedures were guided by systems of care principles, and in another, the existing systems of care structure adapted to changes in leadership and tempered efforts to implement abrupt, reactive change in favor of more conservative service approaches.

In a fully functioning system of care, all human service agencies adopt similar guiding principles and processes. In practice, systems of care principles rarely evolve across human service agencies at the same time or rate. While change leaders may become frustrated with the pace of change and participation in the collaborative change process, each agency has to do the work of integrating the principles into its organizational culture. Consequently, child welfare administrations must build a vertically integrated system while working across organizational boundaries to reach agreements based on shared values/principles and overcome historic and current impediments to interagency coordination and collaboration.

Each of the grant communities is unique in its approach to systems change but collectively, they address many of the challenges faced by the entire child welfare community. Each issue of *A Closer Look* focuses on one of the systems of care principles and highlights how the grant communities have applied the principle in their work. The reports summarize their challenges, highlight emerging and promising practices, and describe lessons learned when promoting systems change. Each issue provides information communities should consider in planning, implementing, and evaluating effective systems change in child welfare, and is intended as a tool for administrators and policymakers leading systems change initiatives.

Implications for Administrators and Stakeholders

A Closer Look offers valuable information for Federal, State, tribal, and local administrators and policy-makers. While *A Closer Look* also will be useful for other key stakeholders, including child welfare frontline staff, interagency partners, providers, and families, the principal audience is individuals who have responsibility and authority to promote and support systems change.

A Closer Look:

- Informs child welfare decision-makers about how systems of care promote and guide systems change, both in policy and practice, to address the requirements of the Child and Family Services Reviews.
- Highlights innovations or changes in governance, policy, or practice that may be useful for addressing common challenges in child welfare systems.
- Promotes the effective use of systems of care principles and processes in guiding sustainable systems change among child welfare administrators and decision-makers.

Each issue of *A Closer Look* shares ideas and actions that administrators and decision-makers may adopt as they work to improve outcomes in permanency, safety, and well-being for children and families. Although each issue addresses a different systems of care principle, operationalizing a single principle will not lead to a fully functioning system of care. An effective child welfare driven system of care is based on the synergy of the principles as they are used to guide the work throughout an organization, the broader service system, and the community.

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A Study of Service Innovations that Enhance Systems of Care:

Expanding the Array of Services using Networks of Providers in Community-based Integrated Systems of Care

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Nancy Lynn, M.P.H.

The Research and Training Center
for Children's Mental Health

A Study of Service Innovations that Enhance the System of Care

Introduction

During the past two decades, there has been an increasing emphasis on the development of community-based, integrated systems of care to serve children with serious emotional disturbances and their families. Systems of care are based on the understanding that children with serious emotional disturbances have a wide variety of strengths and needs; thus, their services should be individualized, or tailored to the strengths and needs of the child and family. The individualized service plans, jointly developed by the family and the agencies involved with them, is a major underpinning of an integrated system of care. However, implementing such plans requires that a wide array of services be available to meet the individual needs of each child and family in the community system. Efforts to establish a wide array of services involve developing or expanding both traditional mental health services and non-traditional services that can be "wrapped" around the child and family. As a result, considerable attention has been devoted to individualized service planning and to creating a wide range of services. Recently, attention has been directed toward understanding the mechanisms for establishing and maintaining an array of effective and responsive services—while including other systems of care values such as providing choice for families and referring practitioners, and maximizing accountability.

To gain further knowledge about mechanisms for improving or expanding the service system, a study of nine programs across the country was designed. The plan was to focus on programs that had largely moved away from building services within one organization, such as a community mental health center. Rather, programs were identified that included creative mechanisms to:

- coordinate funding across agencies;
- establish provider networks for both formal and informal services;
- include use of data to evaluate provider performance;
- have a central role for parents in the selection of providers; and
- place emphasis on training and supervision to maintain quality.

This study was designed to understand more about these components of integrated systems of care and thus, to advance the field's understanding of provider- and system-level issues. The study was funded by the Center for Mental Health Services.

Study Design

Site Selection: Information about the study focus and methods was distributed to the state mental health directors for children's services and to other informed parties, and site nominations were solicited. Investigators stressed to both informants and sites nominated that this was not to be an evaluation of the programs, per se, but rather an opportunity to describe how each program approached provider, service delivery, evaluation, and collaboration issues. Nine sites were selected and all agreed to participate.

Additionally, sites were chosen to represent a mix of: (a) urban, small city and rural sites; (b) diverse geographic settings across the country; (c) public agency and non-profit settings, and; (d) programs based in mental health centers, schools or other child-serving agencies. The sites also varied by organizational structure and populations served, and the particular types of services offered. Table 1 summarizes key features of each site, and system approaches as related to the study issues:

Table 1
Overview of Selected Study Sites

Site/Project Name	*Population Served/ Treatment Setting*	*Infrastructure/ Provider Network*	*Funding Structure*	*Use of Data*	*Family Involvement*
1. Indiana: Dawn Project; Indianapolis	Services for youth with serious emotional disturbances and their families involved in either the juvenile justice system or the foster care system in Marion County	Non-profit organization leading collaborative effort among child welfare, special education, juvenile justice, and mental health leaders operating under the aegis of the court	Federal grant monies pooled with funds from other agencies and expended according to a case rate; Medicaid funds cover some services		Family plays a strong role in monitoring services; families interview providers, work with the case manager, and monitor progress of the child
2. Kentucky: Building Bridges of Support: One Community at a Time [Bridges Project]	Prevention and intervention strategies for youth with or at risk of developing serious emotional disturbances in rural school settings	Expanded, 3-tier, school-based intervention and prevention model, with universal, targeted and intensive tiers. School staff, Bridges personnel and parent groups provide services; Bridges personnel have offices in the schools	Operated by the Kentucky Department of Mental Health		In the intensive tier, an interagency family team designs services for the child and family; family members are key participants on this team.
3. Massachusetts: Arbour Health Systems Trauma Center, Community Services Program	Intervention in communities in Metro-Boston that have experienced psychological trauma	Community Services Program trains community providers to assist program staff. Trained provider network includes mental health professionals, school personnel and community workers, (e.g., YMCA, Boys and Girl's Club) probation officers, religious leaders	Funded by the Massachusetts Department of Mental Health		
4. Michigan (2 sites): 1. Pathways in Marquette; 2. Community Mental Health Program of Clinton, Eaton and Ingham Counties	Coordinated services for children with severe emotional disturbances in a rural area (Pathways) and the area surrounding East Lansing (Community MH Program)	Part of Michigan's public community mental health and development disabilities system.	Regional Medicaid behavioral health entities. Funding provided by Medicaid managed care program, other health insurance and state funds	CAFAS analysis allows each community mental health program to track its effectiveness and develop a data base to strengthen services	The child and family help the care coordinator/case manager develop individualized service plans
5. Nebraska: Nebraska Family Central, Region III Behavioral Health Services	Services for children with severe emotional disturbances in rural counties in central and south central Nebraska	Partnership of Region III Behavioral Health Services, Nebraska Department of Health and Human Services, and the Nebraska Department of Education. Integrated infrastructure across public agencies	Mental health, child welfare and education funds support services; Region III Behavioral Health Services manages the funds and provider network; Medicaid funds treatment services	The project utilizes MST and progress and outcomes for children are tracked through the data system to provide feedback to parents, child, team, and providers	Parents have a central decision-making role in developing individualized service plans for the child
6. New Jersey: The Children's Initiative	Services for youth with serious emotional disturbances in the State of New Jersey	The State of New Jersey contracted with a private agency to serve as the Administrative Services Organization (ASO) to authorize children to receive services, oversee the appropriateness of the plan, and ensure that providers are available and responsive	Funding sources include agencies within the Health and Human Services Department (but not Education) and Medicaid	The ASO tracks service utilization , needs and costs. Standardized assessment measures and protocols are also utilized.	Expected increase in family and child participation in decision-making

Site/Project Name	*Population Served/ Treatment Setting*	*Infrastructure/ Provider Network*	*Funding Structure*	*Use of Data*	*Family Involvement*
7. New York: Kids Oneida; Oneida County	Services for children with serious emotional disturbances in Oneida County who are at risk for out-of-home placement and/or to shorten the time in such placements	Jointly established by the New York State Office of Mental Health, the New York State Department of Health, and Oneida County; a not-for-profit care management entity operates the program; children are accepted into the program by the Oneida County Committee on Appropriate Placement or the Oneida County Department of Social Services Placement Committee	Funded through a blend of Medicaid, mental health and social services funds, including a bundled case payment fee from Medicaid and a case payment from Oneida County Department of Social Services. Flexible funds are also available for family strengths and needs.		Individualized plans of care are developed in partnership with the child and parent(s), other relevant agencies or providers, and the Kids Oneida individual service coordinator
8. Wisconsin: Wraparound Milwaukee	Services for children with serious emotional disturbances and their families in Milwaukee County who are at risk of entering residential care or psychiatric hospitalization	Part of the Milwaukee Community Mental Health Center. Collaboration among child welfare, juvenile justice, mental health and education	Funds are pooled from child welfare and juvenile justice, along with a capitation payment from Medicaid	A data system is used to manage services and funding, with output on quality assurance/quality improvement and client outcomes	The child and family team designs the service plan, and a strong parent organization oversees service delivery and program management

Eight of the nine sites provide direct assessment services and intervention/treatment services to children and their families Within this group, the Kentucky sites' approach was unique insofar as the majority of their services were delivered through the school system and in the schools. The ninth site, in Massachusetts, was selected because it had established a provider network to deliver services to communities in which traumatic events had occurred, rather than to individual clients.

Method: The study was conducted between September 2002 and June 2003. A case study method was used**,** which involved two-day visits to each community by at least two experienced mental health professionals. Investigators reviewed written documents and data, and interviewed key stakeholders. Depending on the site, the stakeholders included individual and agency providers, parents and children, policy-makers and administrators, and the leadership from related systems (e.g., child welfare, the schools, and juvenile justice). The Massachusetts site also included stakeholders such as city, state and federal elected officials and representatives from the school systems and law enforcement. The Kentucky site included interviews with school personnel at multiple levels.

In order to describe innovations in coordinated funding, provider networks, performance data, family role and provider training and supervision, key elements were identified for site-level examination. These included, depending on the site:

- history and development of the project, especially how the provider system evolved;
- which providers of services become a part of the system;
- how or if children are matched to providers;
- role of the family in selecting the provider and designing the services;
- training for the providers;
- supervision of providers;
- monitoring of service delivery and system performance;
- use of evidence-based practices;
- accountability mechanisms;
- financing of services; and
- types of outcomes measured, procedures for measuring them, and use of the data.

Analyses of the findings and recommendations to the field are based on an integration of the above eleven elements across the nine sites. Extensive field notes were taken on each visit, and written documents were gathered and reviewed. The investigators identified common themes in the sites that were visited. They shared observations with each site, asked questions for clarification, and checked the accuracy of information.

Findings: Central Issues And Common Factors

The study of the sites indicated that they have many strengths, and much was learned from their work. Universally, these sites were found to have developed extensive networks of providers that are managed well. The providers in the networks of the eight treatment sites include those who provide traditional treatment services and those who provide an array of non-traditional wraparound services (e.g., mentoring, therapeutic recreation, and therapeutic aide services, etc.). The providers in the network of the community-focussed Massachusetts project had all received training in trauma psychology, and appeared to follow the protocol of the project for all interventions. In all sites studied, there was evidence that the providers have brought expanded cultural diversity to the system. It was apparent that these providers have remained in the system because of their perceived capacity to deliver good outcomes and because the families considered them to be good and responsive providers.

The network of services in the Bridges Project in Kentucky merits separate description, as it includes an array of services within the schools. For this site, the expanded provider network is school-based and includes principals, teachers, teachers' aides, and school counselors. In each school system involved in the Bridges Project, there were three levels of intervention: 1) school-wide positive mental health interventions for all children, focused on helping them to develop strengths; 2) classroom-based interventions, provided by the teachers with coaching from mental health professionals for children with emerging difficulties; and 3) individual or group treatment for children with diagnosed disorders. Parents were involved in all three levels, with a defined role of support for other parents with children in levels two and three.

Similarly, the Community Services Program in Massachusetts operates within both the public and parochial school systems in Metro Boston, as well as in community sites. Through intensive training to all the school principals, most of the school counselors and many teachers, the program appeared to have prepared the schools well to handle emergencies and to call for support from the program, as needed.

*Collaborative Service Planning***:** Each of the eight treatment sites serves as a central point for referral and service planning for children with serious emotional and behavioral disorders. In Wraparound Milwaukee and the two programs in Michigan, an internal management team determines entrance into the program, but the other agencies seemed pleased with this referral approach and reported that they believe that the "right" children were provided the "right" services. In the Dawn Project, all referrals come through the court for children in the protective services, foster care or juvenile justice systems. For the most part, the sister agencies reported satisfaction with this approach. In Kentucky, decisions about entry into the classroom-based interventions and individual services were made jointly by the team of school and mental health personnel. In Nebraska Family Central, New Jersey, and Kids Oneida, interagency teams comprised of agency providers and parents determine who receives services from the system. Except for the Kentucky Bridges Project and Nebraska Family Central, the weakest link in collaborative planning appeared to be the education system.

In all the programs, regardless of how the decisions were made about entry into the program, the service plans were developed jointly by the relevant agencies, and in all sites parents were found to have a key role in the design of services. Investigators found that, overall, strengths-based assessments served as the foundation for service planning. The service plans reviewed were individualized and based on the strengths and needs of the child and family. In all settings, effective care coordination/case management appeared central to the oversight of the service plan with the goal of ensuring that the plan is being implemented, children are getting services, progress is being made, and families are satisfied with the services. Service plan revisions were the responsibility of the care coordinators/case managers.

In a few sites, service planning did not include some of the actual providers, because plans for traditional services are referred to Medicaid providers, who chose not to participate in team planning meetings. Although the program leadership at these sites stated that they would welcome Medicaid provider participation, they felt that—as a lesser alternative—the quality of services was adequately maintained through telephone contact and written reports by the case managers. This was not perceived as an issue of failed communication, but rather of finding alternatives to the providers' presence at team meetings. In other sites, Medicaid providers did participate in service planning. Across sites, any participant in service planning can ask for a review of the plan or a change in the plan. Family members and family organizations reported that they placed considerable value on these functions, felt valued as members of the team, and saw that their input regarding the performance of providers as important.

Building Service Capacity: A wide array of services is essential to make the concept of individualized service planning a reality. In all sites, the service plans reviewed included both traditional services and non-traditional services (i.e., services not usually considered as part of a health benefits package). The flexibility of funds for these programs make this mix possible, as does the availability of providers from whom to purchase these services. In Kentucky, these services are created within the school setting primarily, with only those children in need of intensive clinical services being referred out. In the two Michigan sites and Kids Oneida, many, but not all of the services, were built within community mental health programs. In the other sites, services were provided through contracts with individual providers or provider groups. All of the sites purchased non-traditional services, which might include mentoring, therapeutic recreation, therapeutic aides, respite care, training in skills to improve self-esteem (e.g., music lessons), or vocational training. Typically, these services were purchased on a fee-for-service basis from providers, with agreed-upon rates for units of service, and no guaranteed volume of service. The degree to which particular providers were used was found to be dependent upon the need for the type of service they offered, as determined by individual child and family treatment teams, and the provider choice of the families.

There are several examples of programs that have begun to identify the infrastructure necessary to provide a wide array of services that blend family choice, quality assurance and increased accountability. Their efforts suggest that the development of a large, diverse, and accountable provider network may be an extremely effective way of providing services, and including systems-of-care values such as family-driven services and cultural competence. Examples from the sites include:

- Wraparound Milwaukee has created over 80 different services through contracts with 240 providers, both individual and organizational, in order to offer families genuine choice. To ensure accountability, the contractors have agreed to participate in ongoing quality assurance/quality improvement studies. Investigators found that the project staff used an extensive data system to monitor progress and outcomes by child, by provider and by cost. Families also provide feedback on their experiences with individual providers.
- The Dawn Project in Indianapolis has developed a network of over 500 providers, and has purposefully recruited providers from the minority community. They report that families can suggest providers that they know. There are mechanisms in place for families to interview providers and select those that fit best with their goals and needs, provide feedback on individual providers, and ask to have providers replaced if they are dissatisfied with their services or service experiences.
- Kids Oneida has developed an array of 36 services. They endorsed the availability of flexible funds as giving them the capacity to create new, individualized services as needed.
- New Jersey's State Department of Human Services described ambitious efforts to develop systems of care statewide, integrating child-serving agencies and investing in strong family organizations as partners in this endeavor. They have invested substantially in an independent management structure and are following a carefully designed implementation process. These plans imply recognition that having a range of providers for each type of service is advantageous.
- Nebraska Family Central has focused on developing evidence-based practices within their provider network and has funded training in MST for professionals. Training through the MST program in Charleston, SC includes fidelity checks to ensure that the integrity of services are consistent with the MST model. This is integrated with their treatment team planning process.

- The Massachusetts Community Services Program provides a community-level intervention, but also identifies children and families that are not recovering from trauma within the wide band of normal responses. Individuals who need more intensive services are referred to the service network; they are accompanied by the program staff or network providers to ensure that they are tightly connected to this next level of service.

Financing the Service Capacity: Most of the eight treatment sites have kept a large part of their money flexible and use it to expand the provider network and the available service array, and to fund individualized service plans. These systems were found to be characterized by medium to large provider networks and service arrays, extensive flexible funding, opportunity for families to choose their services and providers, and a strong system of feedback on provider performance. There were two exceptions to this approach, in the two most rural sites studied: (a) Pathways in Marquette, located in the Upper Peninsula of Michigan, primarily uses their flexible funds internally, as the extensiveness of their provider network is limited by availability; and (b) The Bridges Project, which operates in the mountains and hollows of eastern Kentucky has, due to the scarcity of providers, developed the school system as the provider network.

To some extent, all eight treatment programs have blended funds from other agencies to pay for the service systems. In Wraparound Milwaukee, funds are aggregated locally, along with a major portion of funding from the county. The Medicaid funds in Wraparound Milwaukee come directly from the state agency at an established case rate. In the Dawn Project, the two projects in Michigan, Nebraska Family Central, and Kids Oneida, the funds from other agencies are brought together locally to fund services; each agency has an established amount they contribute not tied to the referrals made.

The Medicaid funds were found to flow through the local mental health agency on a fee-for-service basis in all but the Dawn Project. In New Jersey, agency funds are pooled at the state level and are used primarily to support the infrastructure of the program and services not covered by Medicaid; the Medicaid funds are billed directly from the providers to the state Medicaid agency, as fee-for-service. In Kentucky, much of the contribution from the schools is in the form of personnel and space. Medicaid is accessed on a fee-for-service basis. As noted above, the Massachusetts program is fully funded by the Massachusetts Department of Mental Health and is not fee-based.

In each of the eight treatment programs, the amount contributed across agencies was not equal; however, the unevenness did not seem to be an issue. Each program used Medicaid slightly differently. Wraparound Milwaukee and Kids Oneida provided examples where the Medicaid funds have been combined with other funds in a pool. In the two programs in Michigan and Nebraska Family Central, it was reported that Medicaid funding works reasonably well for the programs, although they could identify areas for improvement. In New Jersey, the plan has been to expand the kinds of services that are reimbursable by Medicaid and to increase the rates for many services; providers bill Medicaid directly. The intent is to modify Medicaid to support a wider range of services and providers. The Dawn Project and Kentucky Bridges have the least support from Medicaid, as, in both cases, only those children who receive direct services or case management from the mental health center are eligible for Medicaid funding. These two programs do not compromise services to the children, but rather pay for them from other funds. It was felt that improvements in their Medicaid programs would allow them to use their funds for other purposes, rather than supporting treatment costs. The Massachusetts Community Services Program does not access Medicaid reimbursement or funding.

Role of Parents and Parent Organizations: Parents or parent organizations were found to have established roles in all of the programs. In all the sites, parents were considered equal members of the service planning teams, and care coordinators/case managers involved family members in the implementation of services, review of services and reconsideration of services. In Wraparound Milwaukee, the Dawn Project, and Kids Oneida, parents were viewed as the "purchasers" of services; the parents and the providers both endorsed this viewpoint. Parents "hire" and "fire" providers, and the provider's life with the program is dependent upon the appraisals of parents. In all the programs, provider training, by parents, was reported to be a respected element. Support for parent groups also was evident in these sites. Table 2 shows parent roles across the sites reviewed.

Table 2
Family Roles Across Study Sites

	Family Role				
Site	*Equal member of service planning team*	*Parents train providers*	*Parent orgs provide services*	*Parents viewed as "purchasers" of services*	*Financial support for Parent organizations*
Michigan; Pathways in Marquette	X	X			X
New Jersey's State Department of Human Services	X	X			X
New York: Kids Oneida	X	X	X	X	X
Nebraska Family Central	X	X	X		X
Dawn Project in Indianapolis	X	X	X	X	X
Wraparound Milwaukee	X	X	X	X	X
Kentucky: Building Bridges	X	X	X		X
Michigan: Community Mental Health Center	X	X			X
Massachusetts Community Services Program	X	X			

In some sites, such as the Dawn Project, Kids Oneida, the Kentucky Bridges Project, Nebraska Family Central, and Wraparound Milwaukee, parent organizations provide services, such as parent support groups and parent education services, and members accompany family members to service planning meetings, to court and to school planning meetings (IEPs). These organizations provide parent-to-parent support and advocacy to help parents negotiate the system and take an active role in their child's treatment. Family organizations were found to incorporate culturally diverse perspectives to help guide the programs. In the Kentucky Bridges Project, the parents' organization which operates within the schools was central to the services provided which included mentoring, counseling and a broad range of supports for families.

Most of the sites have committed to financial support for the parent organizations. New Jersey has provided funding statewide to parent organizations from the state office. The parent organizations appeared to have considerable potential as advocates within the programs for quality services for children and families, and externally as advocates for the programs on issues such as continued funding and program expansion. And in all cases, parent organizations were reported to be very important to caregivers as their children enter the system.

*Training and Supervision of Providers***:** All the programs demonstrated a focus on ongoing training and supervision of service providers to ensure fidelity to systems-of-care principles and to quality services. Good relationships were evident with providers and provider agencies, as evidenced by their participation in training to gain/maintain understanding of program philosophy and service emphasis. All of the programs have focused on re-training existing providers and suggesting alternatives to traditional modalities of service provision. Investigators found a large number of non-traditional service providers who offer mentoring, supervision activities for clients, advocacy for clients and families in school and in court, and other interventions as the needs of the clients dictate. Of note were contracts for services provided by neighborhood organizations or individuals within neighborhoods, fostering services that are responsive to local ethnic and racial groups. The strong link evident between service providers and care coordinators/case managers has clearly informed the programs and supported approval of non-traditional interventions.

The school-based Kentucky Bridges Project's training program is focused on school personnel, including principals, teachers, aides, and counselors. School personnel serve as "providers," except in the case of children with the most serious problems. The school personnel have received extensive training in contemporary mental health concepts to be applied universally throughout the schools. They have also been trained in classroom behavioral management techniques to promote support of individual children with problems within the context of the whole classroom.

The Massachusetts Community Services Program's approach was designed to ensure that providers conform to a evidence-based protocol. The program's rigorous training curriculum has two levels: 1) introductory training, which equips providers with skills necessary to work as part of the team; and 2) advanced training, which consists of team-leader training. Annual re-training is required. The program staff provide ongoing supervision of the providers in the network.

Investigators found that Wraparound Milwaukee provided an outstanding example for facilitating a change in focus among providers. This program has been very successful working with traditional, residential programs to broaden the array of services they provide, help shift beliefs about how to provide services to those with intensive needs and deliver services outside of the residential setting. Wraparound Milwaukee staff directly supervise the staff of contracted agencies to ensure model constancy and quality services.

New Jersey started a statewide rollout of a systems-of-care approach with approximately half the counties in the state. Investigators found a comprehensive plan for training, at all levels of providers, and for most, if not all, aspects of services. Training covers the systems-of-care philosophy, along with clinical and administrative issues (e.g., data input, use of the information system, forms, etc.). Program staff have consulted with programs with successfully implemented systems of care, primarily Wraparound Milwaukee and the Dawn Project, for advice, training, and supervision related to service delivery. Videoconferencing is used when trainers/supervisors from Wraparound Milwaukee and the Dawn Project are not on-site.

In the Dawn Project and Wraparound Milwaukee, their states support training for replication. In these states, the mental health state agency has provided funding for the programs to conduct training across the state to sites that are interested and ready to replicate these services.

*Use of Data to Manage the System***:** All of the programs have established mechanisms to collect data and use it for project management, indicating that this may be a very important feature of good programming. In particular, the Dawn Project, Nebraska Family Central, Kids Oneida, and Wraparound Milwaukee demonstrated success in utilizing a well-developed management information system to support management decisions about funding provider contracting, as well as for quality assurance/quality improvement studies, service utilization studies and outcome studies. The Children's Initiative in New Jersey's system was not complete at the time of the study, but substantial plans were in progress and substantial dollars had been committed, indicating the state's commitment to using data to manage the system.

All of these sites have invested substantially in information systems and express a high priority on using these systems to collect meaningful data. It was evident that data collected were used as management tools and as tools to convey program progress and success. The reliance on quality information systems that serve many purposes seems essential, and these programs represent a new generation of management in this area. Importantly, all programs had staff dedicated to program evaluation activities.

Additionally, the Dawn Project, Nebraska Family Central, the Massachusetts Community Services Program and Kids Oneida have contracted with universities to obtain independent assessments of their programs. The two programs in Michigan are part of a state-university partnership that provides program evaluation.

In terms of data systems, Michigan's programs deserve special attention Michigan's programs were given priority during site selection because the state's child mental health office had introduced outcomes-driven program evaluation conducted jointly with university faculty. Each child receiving services at the local community mental health program is regularly assessed using a well-validated measure of child progress and outcome (the Child and Adolescent Functional Assessment Scale; CAFAS, Hodges, 2000), and data are submitted to the state's office of Mental Health Services to Children and Families. Scores are aggregated for each community mental health center, producing an overall picture of progress and outcomes by community programs. The two sites in Michigan selected for study had shown the best progress and outcomes, statewide. Discussions with these program informants indicated that they use their data for internal assessment, to understand when different approaches with a client might be needed, and to drive their service system. Data also are used with partner agencies to review client progress. Although both of these programs were somewhat more traditional in service provision than the other six service programs studied, their approach to

clients and services is noteworthy. From the top leadership of the program to the direct service staff, there was a clear commitment to quality, to intensive outreach to clients, to "going the extra mile" to engage clients and their families to provide individualized services.

Specific Areas of Concern: Although each site was exemplary overall, some areas for improvement were evident. In some sites, the program leaders were aware of these issues and were seeking to remedy them. In other sites, the observations of the reviewers provided new information. Areas of concern, aggregated across sites, included:

- limited psychiatric services and therefore limited capacity for medical diagnoses and the use of medication;
- a small number of providers for certain services, which meant an over-reliance on these providers;
- limited access to Medicaid reimbursement for services, primarily because of limitations in the state's Medicaid Plan;
- limited participation of the school systems in service planning;
- limited assessment of the quality of services, with feedback to the providers so that they can correct problems, if present; and
- absence of comparison data with other sites or with other types of services.

Although these concerns existed in some of the sites, in other sites most of these concerns were nonexistent, indicating the strengths of the programs. Thus, these six concerns seem to reflect the most difficult barriers—barriers that even successful programs are struggling to overcome.

Summary

This study's purpose was to gain understanding of the mechanisms for expanding or improving a service network, with a primary focus on how the use of providers was evolving. Nine sites were selected for the study, based on nominations from state mental health leaders and other knowledgeable persons. Overall, these programs were outstanding and they provided examples of "cutting edge," quality work. The purpose of the study was not to evaluate these programs but to learn from them.

Eight treatment programs and one community services program participated in this study and although each had a somewhat different approach to service provision, there were similarities that are worth noting. In all eight of the treatment programs, we found a high priority on individualized service plans. All nine programs focused on treating each child and family with care and respect. The role defined for families in these programs was exceptional—in determining service plans, selecting providers, evaluating providers, and providing support for other families. Respect for culture and ethnicity was also apparent. Each of these programs had developed strong partnerships with their communities and community agencies. In the eight treatment sites, the child-serving agencies have come together to plan services for children and to share in the funding of services. Partner community agencies provided in-kind and monetary contributions to the program and shared the responsibilities for the program. All the programs used data to manage their systems and they were open to sharing information about their programs with their communities. The attitudes and actions of both the program leaders and the staff reflected commitment to and respect for their clients. All in all, these programs have put into practice the spirit, principles and philosophy of systems of care.

Other, newer contributions from the sites include:

- The concept of service array has been broadened by the more extensive use of non-traditional services;
- If providers of needed non-traditional, wraparound services were not available in the community, the programs have trained them in both program philosophy and service provision;
- The usual way of expanding services, that is, hiring more staff, has been replaced by the more flexible approach of purchasing from a wide group of providers, many of whom were members of the community;
- Intensive training and supervision are provided to ensure that providers adhere to the program philosophy and approach;
- Parents evaluate the effectiveness of the services, as well as their satisfaction with the services;

- The programs purchase outcomes rather than just services;
- They use good business practices to develop "performance-based" contracts; and
- They use data to drive their systems.

The programs studied also offer information about directions for the future, which includes a continuing need to focus on the following areas for improvements:

- Relationships across agencies, especially with the schools;
- Funding of services, especially Medicaid;
- Expanding the provider networks, especially for non-traditional services; and
- Increasing evaluations of the quality, effectiveness, and impact of services.

All in all, the programs studied represent cutting-edge approaches to children, families and communities. They provide ideas about promising new directions for services.

Reference

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