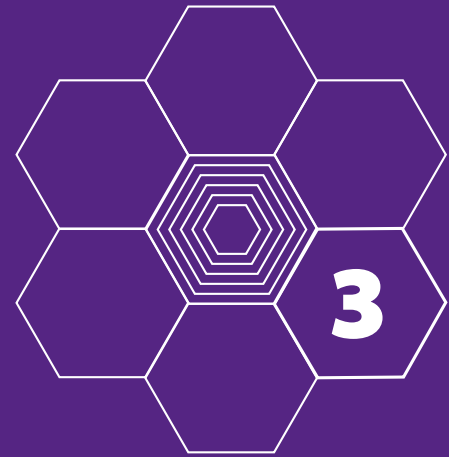


# Effective Financing Strategies for Systems of Care:

## Examples from the Field

*A Resource Compendium for Developing a Comprehensive Financing Plan*

Beth A. Stroul, M.Ed.  
Sheila A. Pires, M.P.A.  
Mary I. Armstrong, Ph.D.  
Jan McCarthy, M.S.W.  
Karabelle Pizzigati, Ph.D.  
Ginny M. Wood, B.S.



The Research and  
Training Center for  
Children's Mental Health

### RTC Study 3

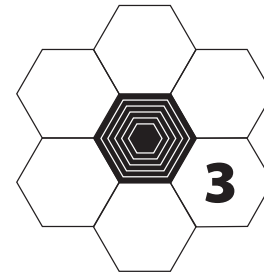
Financing Structures and Strategies  
to Support Effective Systems of Care



---

## RTC Study 3:

Financing Structures and Strategies  
to Support Effective Systems of Care



# Effective Financing Strategies for Systems of Care: **Examples from the Field**

*A Resource Compendium for Developing a Comprehensive Financing Plan*

---

Beth A. Stroul, M.Ed., Sheila A. Pires, M.P.A., Mary I. Armstrong, Ph.D., Jan McCarthy, M.S.W., Karabelle Pizzigati, Ph.D., & Ginny M. Wood, B.S.

---

### Suggested Citation:

Stroul, B.A., Pires, S.A., Armstrong, M. I., McCarthy, J., Pizzigati, K., & Wood, G.M., (2008). *Effective financing strategies for systems of care: Examples from the field—A resource compendium for developing a comprehensive financing plan (RTC study 3: Financing structures and strategies to support effective systems of care, FMHI pub. # 235-02)*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute (FMHI), Research and Training Center for Children's Mental Health. **(FMHI Publication #235-02)**

---

### FMHI Publication #235-02

**Series Note:** RTC study 3: Financing structures and strategies to support effective systems of care, FMHI pub. # 235-02)

**First Printing:** March 2008

© 2008 The Louis de la Parte Florida Mental Health Institute

**RTC Study 3:** Financing Structures and Strategies to Support Effective Systems of Care is a study of the Research and Training Center for Children's Mental Health. The Center is jointly funded by the National Institute on Disability and Rehabilitation Research, U.S. Department of Education and the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration under grant number **H133B040024**.

**Permission to copy** all or portions of this book is granted as long as this publication, the Louis de la Parte Florida Mental Health Institute, and The University of South Florida are acknowledged as the source in any reproduction, quotation or use.

**Partial Contents:** Introduction – RTC: Study 3 Background – How to Use this Document – Overview of Sites Studied – Effective Financing Strategies Framework – I. Identification of Current Spending and Utilization Patterns Across Agencies – II. Realignment of Funding Streams and Structures – III. Financing of Appropriate Services and Supports – IV. Financing to Support Family and Youth Partnerships – V. Financing to Improve Cultural and Linguistic Competence and Reduce Disparities in Care – VI. Financing to Improve the Workforce and Provider Network – VII. Financing for Accountability – VIII. Financing Strategies for Tribal Systems of Care – Conclusion – Order Forms for RTC Study 3 publications.

### Available from:

Department of Child and Family Studies  
Division of State and Local Support  
**Louis de la Parte Florida Mental Health Institute**  
**University of South Florida**  
13301 Bruce B. Downs Boulevard  
Tampa, FL 33612-3899 (813) 974-6271

This publication is also available **free** on-line as an Adobe Acrobat **PDF** file:

<http://rtckids.fmhi.usf.edu/study03.cfm> or

<http://pubs.fmhi.usf.edu> click **Online Publications** (By Subject)



Research and Training Center  
For Children's Mental Health



NIDRR  
National Institute  
on Disability and  
Rehabilitation Research



UNIVERSITY OF  
SOUTH FLORIDA

Louis de la Parte  
Florida Mental Health Institute

---

Events, activities, programs and facilities of The University of South Florida are available to all without regard to race, color, marital status, sex, religion, national origin, disability, age, Vietnam or disabled veteran status as provided by law and in accordance with the University's respect for personal dignity.

---

# Acknowledgements

Effective Financing Strategies for Systems of Care: **Examples from the Field** is one in a series of technical assistance tools and resources that are produced by the five-year study, **Financing Structures and Strategies to Support Effective Systems of Care**. During the study period, the support and participation of many individuals has been invaluable to the study team in clarifying the study questions and goals.

First, we want to thank the federal agencies that have funded this project and recognize the importance of financing in developing effective systems of care — the National Institute on Disability and Rehabilitation Research (NIDRR) of the U. S. Department of Education and the Child, Adolescent and Family Branch of the Center For Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), U. S. Department of Health and Human Services.

We also thank the members of our national Panel of Financing Experts, who contributed their time and expertise in helping us to frame the critical questions and issues for the study:

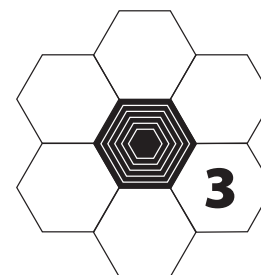
Kamala Allen	Doreen Cavanaugh	Nadia Cayce	Joseph Coccozza
Mark DeKrai	Richard Dougherty	Holly Echo-Hawk	David Fairbanks
Jamie Halpern	Cheryl Hayes	Bruce Kamradt	Judith Katz-Leavy
Chris Koyanagi	Jody Levison-Johnson	Ken Martinez	Mary Jo Meyers
Peggy Nikkel	David Sanders	Tessie Schweitzer	Harry Shallcross
Sue Smith	Constance Thomas	Robin Thrush	Nancy Weller
Rita Vandivort-Warren			

Thanks also to Vivian Jackson of the National Center for Cultural Competence at Georgetown University for her review of issues related to cultural competence and racial and ethnic disparities; to Roxann McNeish for her assistance with editing and revisions; and to Bill Leader for the page layout and design of this document.

---

## **RTC Study 3:**

Financing Structures and Strategies  
to Support Effective Systems of Care



# Effective Financing Strategies for Systems of Care: **Examples from the Field**

*A Resource Compendium for Developing a Comprehensive Financing Plan*

---

Beth A. Stroul, M.Ed., Sheila A. Pires, M.P.A., Mary I. Armstrong, Ph.D., Jan McCarthy, M.S.W., Karabelle Pizzigati, Ph.D., & Ginny M. Wood, B.S.

---

**For Information Contact: Mary I. Armstrong, Ph.D.**

Louis de la Parte Florida Mental Health Institute  
Department of Child and Family Studies • Division of State and Local Support  
University of South Florida • 13301 Bruce B. Downs Boulevard • MHC2414 • Tampa, FL 33612

813-974-4601 (Phone) • 813-974-7376 (Fax)  
E-mail: armstron@fmhi.usf.edu

March 2008

**Research and Training Center for Children's Mental Health**

Department of Child and Family Studies  
**Louis de la Parte Florida Mental Health Institute**  
University of South Florida  
Tampa, FL

**Human Service Collaborative**

Washington, DC

**National Technical Assistance Center for Children's Mental Health**

Georgetown University Center for Child and Human Development  
Washington, DC

**Family Support Systems, Inc.**

Peoria, AZ



Research and Training Center  
For Children's Mental Health

---

# Table of Contents

Page

---

<b>Introduction</b> .....	1
RTC Study 3 Background .....	1
How to Use this Document .....	3
Overview of Sites Studied .....	3
Effective Financing Strategies Framework .....	14
Developing a Strategic Financing Plan .....	15
<b>I. Identification of Current Spending and Utilization Patterns Across Agencies</b> .....	17
A. Determine and Track Utilization and Cost of Behavioral Health Services for a Defined Population .....	17
B. Identify the Types and Amounts of Funding for Behavioral Health Services Across Systems .....	23
<b>II. Realignment of Funding Streams and Structures</b> .....	24
A. Utilize Diverse Funding Streams .....	25
B. Maximize Federal Entitlement Funding .....	34
C. Redirect Spending from “Deep-End” Placements to Home and Community-Based Services .....	48
D. Support a Locus of Accountability for Service, Cost, and Care Management for Children With Intensive Needs .....	59
E. Increase the Flexibility of State and/or Local Funding Streams and Budget Structures .....	67
F. Coordinate Cross-System Funding .....	69
G. Incorporate Mechanisms to Finance Services for Uninsured and Under insured Children and their Families .....	72
<b>III. Financing of Appropriate Services and Supports</b> .....	76
A. Provide a Broad Array of Services and Supports .....	77
B. Promote Individualized, Flexible Service Deliver .....	86
C. Support and Provide Incentives for Evidence-Based and Promising Practices .....	92
D. Promote and Support Early Childhood Mental Health Services .....	96
E. Promote and Support Early Identification and Intervention .....	102
F. Support Cross-Agency Service Coordination .....	108
<b>IV. Financing to Support Family and Youth Partnerships</b> .....	112
A. Support Family and Youth Involvement and Choice in Service Planning and Delivery .....	113
B. Finance Family and Youth Involvement in Policy Making .....	121
C. Finance Services and Supports for Families and Other Caregivers .....	128
<b>V. Financing to Improve Cultural and Linguistic Competence and Reduce Disparities in Care</b> .....	133
A. Provide Culturally and Linguistically Competent Services and Supports .....	133
B. Reduce Disparities in Access to and Quality of Services and Supports .....	142
<b>VI. Financing to Improve the Workforce and Provider Network</b> .....	146
A. Support a Broad, Diversified, Qualified Workforce and Provider Network .....	146
B. Providing Adequate Provider Payment Rates .....	154

---

<b>VII. Financing for Accountability</b> .....	157
A. Incorporate Utilization, Quality, Cost, and Outcomes Management Mechanisms .....	158
B. Utilize Performance-Based or Outcomes-Based Contracting .....	169
C. Support Leadership, Policy, and Management Infrastructure for Systems of Care .....	170
D. Evaluate Financing Policies to Ensure that they Support and Promote System of Care Goals and Continuous Quality Improvement .....	173
<b>VIII. Financing Strategies for Tribal Systems of Care</b> .....	176
Finance Tribal Systems of Care Through Collaboration Among States and Tribes and Coordination of Federal, State, Local, and Tribal Financing Streams .....	176
<b>Conclusion</b> .....	181
Technical Assistance .....	181
Contextual, Environmental, Fiscal or Other Factors that Will Influence Financing Policies and Strategies for Systems of Care .....	181
Order Forms for Study 3 Publications .....	182

## List of Tables

Page

---

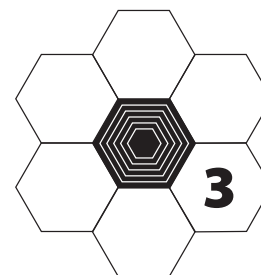
<b>Table 1</b> Use of Multiple System Resources .....	25
<b>Table 2</b> Use of Multiple Medicaid Options .....	41
<b>Table 3</b> Array of Services and Supports Examined .....	77





**RTC Study 3:**

Financing Structures and Strategies  
to Support Effective Systems of Care



## Effective Financing Strategies for Systems of Care: **Examples from the Field**

*A Resource Compendium for Developing a Comprehensive Financing Plan*

Beth A. Stroul, M.Ed., Sheila A. Pires, M.P.A., Mary I. Armstrong, Ph.D., Jan McCarthy, M.S.W., Karabelle Pizzigati, Ph.D., & Ginny M. Wood, B.S.

## Introduction

### RTC Study 3 Background

The Research and Training Center for Children’s Mental Health (RTC) at the University of South Florida is conducting several five-year studies to identify critical implementation factors which support communities and states in their efforts to build effective systems of care to serve children and adolescents with or at risk for serious emotional disturbances and their families. One of these studies examines financing strategies used by states, communities, and tribes to support the infrastructure, services, and supports that comprise systems of care.

The study of effective financing practices for systems of care was initiated in October 2004 and is conducted jointly by the RTC, the Human Service Collaborative of Washington, DC, the National Technical Assistance Center for Children’s Mental Health at Georgetown University, and Family Support Systems, Inc. of Arizona.

#### **The purposes of the study are to:**

- Develop a better understanding of the critical financing structures and strategies to support systems of care for children and adolescents with behavioral health disorders and their families
- Examine how these financing strategies operate separately and collectively
- Promote policy change through dissemination of study findings and technical assistance to state and local policymakers and their partners

The study of effective financing strategies for systems of care uses a participatory action research approach, involving a continuous dialogue with key users on study methods, findings, and products. The study uses a multiple case study design; and data collection and analysis includes a mix of qualitative and quantitative methods.

Initial study tasks included convening a panel of financing experts, including state and county administrators, representatives of tribal organizations, providers, family members, and national financing consultants to develop a list of critical financing strategies and study questions. The critical financing strategies were used to create the first study product — *A Self Assessment and Planning Guide: Developing a Comprehensive Financing Plan*<sup>1</sup> — that addresses seven important areas to assist service systems or sites (states, tribes, territories, regions, counties, cities, communities, or organizations) to develop comprehensive and strategic financing plans for systems of care:

- I. Identifying spending and utilization patterns across agencies**
- II. Realigning funding streams and structures**
- III. Financing appropriate services and supports**
- IV. Financing to support family and youth partnerships**
- V. Financing to improve cultural and linguistic competence and reduce disparities in care**
- VI. Financing to improve the workforce and provider network**
- VII. Financing for accountability**

The critical financing strategies also were used as the basis for developing site visit protocols to explore the implementation of these strategies in a purposively selected sample of states and communities. Study team members and members of the national expert panel nominated a number of states and communities as potential sites to study, based on the knowledge of effective financing strategies at those sites. Telephone interviews with key informants knowledgeable about each of the sites nominated, along with review of documents and information from prior related studies, led to the identification of a sample of sites to include in the first wave of site visits and interviews. The sample included four states and four regional or local areas:

**States:**

- Arizona and Maricopa County, AZ,
- Hawaii,
- New Jersey, and
- Vermont

**Regional/Local Areas:**

- Bethel, Alaska,
- Central Nebraska,
- Choices based in Indianapolis, Indiana, and
- Wraparound Milwaukee

<sup>1</sup>This publication is available on-line at: <http://rtckids.fmhi.usf.edu/study03.cfm>

Site visits and telephone interviews with key informants in these sites were conducted from September 2006 to February 2007. Site visits were conducted in Arizona at the State level and in Maricopa County (Phoenix), Hawaii, Vermont, Bethel, and Central Nebraska and involved in-depth interviews with key stakeholders about the various financing approaches in use. Abbreviated site visits and telephone interviews were used to gather updated data from New Jersey, Choices, and Wraparound Milwaukee, all of which had been studied previously by members of the study team. Examples of effective financing strategies in each of the sites were reviewed and analyzed by the study team.

## How to Use this Document

This document presents the results of the first wave of site visits and is intended to be a companion to the *Self-Assessment and Planning Guide*. It presents examples of effective financing strategies for each of the seven areas discussed in the *Guide*, based on information gathered through the site visit and interview process. It is intended as a technical assistance document to assist stakeholders to identify strategies that might be implemented or adapted in their own states and communities. As stakeholders use the *Guide* to craft a strategic financing plan, this document can be used to identify and learn about specific strategies in each area that have been found to be effective in other states and communities.

While all seven areas are important components of a strategic financing plan, it is not necessary to move sequentially through the seven areas. Readers can review the table of contents to find strategies in specific areas of interest or need. Thus, this document is designed to serve as a compendium of strategies, and can be used as a reference and resource as states and communities are designing and implementing strategic financing plans for systems of care.

## Overview of Sites Studied

**Full descriptions of each of the sites are provided below. To summarize, the sites included:**

- **Arizona and Maricopa County:** A statewide behavioral health carve out operated under an 1115 waiver utilizing locally-based, capitated Regional Behavioral Health Authorities (i.e., behavioral health managed care organizations — BHOs); the BHO in Maricopa County (Phoenix) at the time of the site visit was Value Options
- **Hawaii:** A statewide behavioral health system operated through the schools and managed care organizations for children needing short-term services and through the state Child and Adolescent Mental Health Division for children with serious emotional challenges and their families
- **New Jersey:** A behavioral health carve out utilizing a statewide Administrative Services Organization and locally-based Care Management Organizations and Family Support Organizations
- **Vermont:** A statewide mental health system managed by the Department of Mental Health utilizing legislatively-mandated state and local interagency teams and designated provider agencies

- **Bethel, Alaska:** The administrative and transportation hub for the 56 villages in the Yukon-Kuskokwim Delta, with behavioral health services administered by the Yukon Kuskokwim Health Corporation (YKHC), a Tribal Organization, which administers a comprehensive health care delivery system for the rural communities in southwest Alaska
- **Central Nebraska:** A 22-county partnership among Region 3 Behavioral Health Services, the Central Service Area of the Office of Protection and Safety, the State Department of Health and Human Services (DHHS), and Families CARE, a family-run organization, providing services and supports to several sub-populations of children with serious behavioral health challenges or at high risk
- **Choices, Inc:** A nonprofit, community care management organization operating in Marion County, Indiana; Hamilton County, Ohio; Montgomery County, Maryland; and Baltimore City, MD, which coordinates services for children and families with serious behavioral health challenges who are involved in one or more governmental systems
- **Wraparound Milwaukee:** A behavioral health population carve-out, operated by the Milwaukee County, Wisconsin Behavioral Health Division, serving several subsets of children and youth with serious behavioral health challenges and their families who also are involved in child welfare and juvenile justice systems

## AZ Arizona and Maricopa County



**Arizona** provides behavioral health services to children and adolescents and their families through an 1115 Medicaid managed care research and demonstration waiver. The Arizona State Medicaid agency contracts with the Arizona Department of Health Services (ADHS), Division of Behavioral Health Services (BHS), to manage a behavioral health carve-out. ADHS/BHS, in turn, contracts with four Regional Behavioral Health Authorities (RBHAs), covering six geographic areas throughout the state, and two Tribal Behavioral Health Authorities (TRBHAs). RBHAs receive a capitation for Medicaid and State Children's Health

Insurance (S-CHIP) covered services; they also receive state general revenue dollars and federal mental health and substance abuse block grant monies to provide services to non-Medicaid/S-CHIP populations and to pay for non-Medicaid-covered services.

Arizona has a population of about six million, with nearly two million children under 18 (about 32% of the overall state population). Maricopa County (Phoenix) has most of the state's population, with over 3.5 million total and 1.2 million children under 18 (34%). The RBHA in Maricopa County at the time of the site visit was Value Options (VO), a commercial behavioral health managed care company.<sup>2</sup> VO in Maricopa County contracts with seven Comprehensive Service Providers (CSPs), who receive a sub capitation (which

<sup>2</sup> Value Options was the BHO at the time of the site visit. Through a recent re-procurement, Magellan became the BHO in the county.

excludes residential treatment facilities, which VO authorizes directly). The CSPs contract on a fee-for-service basis with many other providers, and VO also holds about 20 contracts with “niche” providers and Community Service Agencies (CSAs), which are community-based, often nontraditional providers that are not required to meet full licensure requirements as a behavioral health agency. These are a new type of provider developed by the state, and they are paid on a fee-for-service basis.

In 1993, an EPSDT-related law suit, known as “Jason K” or “JK,” was filed in Arizona on behalf of the now 34,000 Medicaid-eligible class members under age 21 in need of behavioral health services. The JK suit was settled in 2001, and the JK settlement agreement forms the basis for the child/adolescent behavioral health system in the state. Technically, the agreement applies to the State Medicaid agency (i.e., the Medicaid managed care system) and ADHS/BHS; however, these systems work collaboratively across systems on implementation since the suit covers children in child welfare and juvenile justice, as well as Native American youth. What has come to be known as “the Arizona Vision” underpins the settlement agreement. The “vision” is a statement of 12 principles based on system of care values. The principles include: collaboration with the child and family, (priority on) functional outcomes, collaboration with others, accessible services, best practices, most appropriate setting, timeliness, services tailored to the child and family, stability, respect for the child’s and family’s cultural heritage, independence, and connection to natural supports.

The principles provide the philosophical foundation for reform of the system, including expansion of covered services, intake, assessment, and service planning processes, which involve a child and family team (or wraparound) approach. More information about the Arizona system can be found at:

<http://www.azdhs.gov/bhs>.

## HI Hawaii



**Hawaii**, located 2,300 miles southwest of San Francisco, is a 1,523-mile chain of islets and eight main islands — *Hawaii, Kahoolawe, Maui, Lanai, Molokai, Oahu, Kauai, and Niihau*. The state’s population is approximately 1.3 million; 23.5% of the population is under age 18. The population is diverse, with more ethnic and cultural groups represented in Hawaii than in any other state. According to recent census data, 27% of the population is White, 41% Asian, 9% Native Hawaiian and other Pacific Islander, 8% Hispanic, 2% Black, and 20% reporting two or more races.

Nearly 27% of households reported speaking a language other than English at home. Significant challenges to service delivery are presented by the state’s island geography, as well as by its diverse population, and numerous cultures and languages.

Hawaii’s children’s mental health system is administered by the state government, specifically the Child and Adolescent Mental Health Division (CAMHD) of the Hawaii Department of Health (DOH). CAMHD’s mission is “to provide timely and effective mental health services to children and youth with emotional and behavioral challenges and their families...within a system of care that integrates [system of care] principles, evidence-based services, and continuous monitoring.” A major system emphasis is on ensuring that all services and supports are individualized, youth-guided, and family-centered, as well as on services being locally available, community-based, and least restrictive.

Under the CAMHD structure are seven public Family Guidance Centers (community mental health centers) located throughout the state that are responsible for mental health service delivery to children and adolescents and their families. CAMHD also contracts with a range of private organizations to provide a full array of mental health services to children and adolescents and their families. Public employees within the

---

Family Guidance Centers provide care coordination services, some assessment and outpatient services, and arrange for additional services with contracted provider agencies. Additionally, one branch (Family Court Liaison Branch) provides mental health assessments and treatment at the juvenile detention home and the youth correctional facility.

In 1993, a class action lawsuit was filed alleging that the Hawaii Departments of Health and Education were failing to provide adequate and appropriate educational and mental health services to youth with emotional and/or behavioral challenges under the Individuals with Disabilities Education Act (IDEA) and Section 504 of the Rehabilitation Act of 1973. The following year, the state entered into what is referred to as the “Felix Consent Decree” in which it agreed to expand and improve services according to a detailed implementation plan, with the goal of creating a “system of care” that effectively integrates the activities of diverse service-providing agencies and provides a comprehensive array of services. As a result of the Felix Consent Decree in 1994, the legislature sharply increased appropriations for CAMHD and the Department of Education to expand and improve services. In 2004, the court ruled that the state had achieved substantial compliance with the Felix Consent Decree and that court monitoring would be continued for an additional period of time to ensure that progress is sustained. Court monitoring ended in June 2005. More information can be found at <http://www.hawaii.gov/health/mental-health/camhd/index.html>.

Over the past five years, CAMHD’s system of care shifted from a comprehensive mental health service system for all children and youth to a system focused on providing more intensive mental health services to the population of youth with more serious and complex behavioral health disorders and their families. Beginning with fiscal year 2000–2001, the Department of Education took responsibility for serving students with less severe emotional and/or behavioral challenges through newly established school-based behavioral health services. Youth needing less intensive mental health services, such as outpatient counseling, now receive these services through school-based mental health (SBMH) services. The coordinated relationship between the education and mental health systems provides a system of care with the school as the central access point for mental health services for youth with educational disabilities. Youth with emotional challenges that are not impacting their education receive basic mental health services through their private insurance or through their Medicaid health plans which provide assessment and basic levels of outpatient treatment. More intensive services, if needed, for Medicaid-eligible youth, are then obtained through the CAMHD children’s mental health system.

Through a Memorandum of Understanding (MOU) with the state Medicaid agency, CAMHD operates a carve-out under the state Medicaid program that serves youth with serious emotional and behavioral disorders (the Support for the Emotional and Behavioral Development of Youth or SEBD Program). CAMHD receives a case rate from Medicaid for each child in service and provides a comprehensive array of services and supports. Operation as the prepaid mental health plan for Medicaid-eligible youth began in 2002.



## NJ New Jersey



**New Jersey** has a population of about 8.7 million people, with over two million children. It is one of the most densely populated states in the country. The New Jersey Children's System of Care Initiative, which was begun in 2000, is a behavioral health carve out, serving a statewide, total population of children and adolescents with emotional and behavioral disturbances who depend on public systems of care and their families. The population includes both Medicaid and non-Medicaid-eligible children and includes both children with acute and extended service needs. The state describes the initiative as, "not a child welfare, mental health, Medicaid, or juvenile justice initiative, but one that crosses systems." The initiative creates a single statewide integrated system of behavioral health care to replace the previous system in which each child-serving system provided

its own set of behavioral health services. The New Jersey Division of Child Behavioral Health Services, Department of Children and Families, oversees the initiative, the goals of which are to increase funding for children's behavioral health care; provide a broader array of services; organize and manage services; and provide care that is based on the core system of care values of individualized service planning, family/professional partnerships; culturally competent services; and a strengths-based approach to care.

The New Jersey system of care uses a statewide Administrative Services Organization (ASO), called a Contracted Systems Administrator (CSA) to coordinate, authorize, and track care for all children entering the system and to assist the state agency to manage the system of care and improve quality. A non risk-based contract was awarded to Value Options (VO), a commercial behavioral health managed care company, to perform this role. Newly formed nonprofit entities, called Care Management Organizations (CMOs), were created at the local level — one per region — that provide individualized service planning and care coordination for children with intensive, complex service needs. CMOs use child and family teams to develop individualized service plans which are required to be strengths-based and culturally relevant; the CMOs employ care managers who carry small caseloads. The system also incorporates partnership with families by creating and funding Family Support Organizations (FSOs) in each region that fulfill a range of support and advocacy functions and also provide Family Support Coordinators and Community Resource Development Specialists to provide peer support, informal community resources, and advocacy to families served by the CMOs.

The New Jersey system of care incorporates a broad, flexible benefit design that includes a range of traditional clinical services, as well as nontraditional services and supports. To achieve this, the initiative expanded services covered under Medicaid through the Rehabilitation Services Option and covers other services through non-Medicaid dollars. The initiative uses a "single payer system" through the state Medicaid agency for both Medicaid and non-Medicaid eligible children served in the system. More information can be found at <http://www.nj.gov/dcf/behavioral>.

## VT Vermont



U.S. census data estimate **Vermont's** population at 623,000 persons in 2005; slightly more than 135,000 — about 22% — were children under age 18. In the late 1990s, it was estimated that about 12% of Vermont's children and youth (16,200 children and adolescents) experience serious or severe emotional disturbance each year. The number of children who received public children's mental health services increased from about 3,750 in 1989 to slightly more than 10,000 in 2005.

Vermont's system of care for children and adolescents with severe emotional disturbance and their families took shape in the 1980s. In 1982, Vermont was the first state to secure and implement a Medicaid home and community-based services waiver for children with serious emotional disorders. In 1985, Vermont received an NIMH-funded Child and Adolescent Service System Program (CASSP) planning grant that provided the means to develop the vision and values necessary to create and sustain a system of care. In 1988, Vermont enacted Act 264, which codified its vision and structure for a coordinated system of care for this population. Act 264 articulated system of care values and principles and established an infrastructure to advance the system of care approach statewide. The law institutionalizes interagency cooperation and coordination at the state and local levels by: establishing a definition of severe emotional disturbance for all agencies to use; mandating state and local interagency teams; creating an advisory board appointed by the governor to advise the partnering state agencies on the development and operation of the system of care; entitling eligible children and youth to a coordinated services plan; and, mandating and setting forth a structure for family involvement.

Vermont's Department of Mental Health is the lead state office for children's mental health. It is closely aligned with the state's Department of Health due to a recent reorganization within the umbrella Agency of Human Services. A Designated Agency within each region (e.g., a community mental health center) serves as the local focal point for management and coordination of the system of care. Five core services are available within each geographic area of the state. Additional services and support are provided under contract with the designated agency, as well as several statewide services. The core services are categorized as immediate crisis response; clinic-based and outreach treatment; family support; and prevention, screening, referral and community consultation. Statewide services are emergency/hospital diversion, intensive residential services, and hospital inpatient services.

Operationally, an interagency treatment team of family members and service providers that is led by a care coordinator develops the individualized coordinated service plan for each child. One agency has legal responsibility for ensuring that a coordinated service plan is in place. If the child is in the custody of the state's child welfare agency, the Department for Children and Families, that agency is responsible. If the issues are primarily associated with the child's educational environment and functioning and the child is not in state custody, then the local school district is responsible. In all other cases, the mental health system's Designated Agency (e.g., community mental health center) is responsible for developing the coordinated services plan that outlines goals and needed supports and services. If problems or issues arise that the individual treatment team cannot resolve, the team or any member may initiate a referral to the Local Interagency Team (LIT) in the region for help. The State Interagency Team is a state-level forum for the next round of consideration or assistance should issues not be resolved locally.

The Agency of Human Services and the Department of Education signed a new agreement in 2006 that broadened the scope of eligible youth and the group of providers who participate in and contribute to service planning for them. With the new interagency agreement, eligibility expanded from the original single disability of severe emotional disturbance to include youth with any of the 14 disabilities in state and



federal special education law. These children and their families can access coordinated plans that “include but are not limited to developmental services, alcohol and drug abuse programs, traumatic brain injury programs and pre and post adoption services.”

Vermont’s children’s mental health partners also are exploring new approaches to financing services for children with multiple, severe needs. Under the authority of the State’s Global Commitment Medicaid waiver received in 2005, the state is working to establish a mental health funding resource that would create a pool of resources funded by several agencies for services and supports for children with multiple and serious needs. More information can be found at <http://healthvermont.gov/mh/programs/cafu/child-services.aspx>.

## AK Bethel, Alaska



**Bethel** is a city located 340 miles west of Anchorage. According to 2005 Census Bureau estimates, the population of the city is 6,262. Bethel is the largest community in western Alaska and the 9th largest municipality in the state. It lies inside the largest wildlife refuge in the United States. It is an administrative and transportation hub for the 56 villages in the Yukon-Kuskokwim Delta, one of the biggest river deltas in the world, roughly the size of Oregon.

The Delta has approximately 20,000 residents; 85% of these are Alaska Natives, both Yup’ik Eskimos and Athabaskan Indians. Nearly half of the region’s population is children due to the high birth rate and young median age. The main population center and service hub is the city of Bethel; each of the 56 villages within the Delta has up to 850 people. Most residents live a traditional subsistence lifestyle of hunting, fishing, and gathering, and over 30% have cash incomes well below the federal poverty threshold.

Precipitation averages 16 inches a year in this area, with snowfall of 50 inches. The average low temperature in July is 49°F and the average high is 63°F, although temperatures as low as 32°F or as high as 87°F have been recorded in July. In January, the average low is 1°F and the average high is 12°F, while extremes of –49 to 49°F have been recorded.

Health and behavioral health services in this region are the responsibility of the Yukon Kuskokwim Health Corporation (YKHC), which administers a comprehensive health care delivery system for the 56 rural communities in southwest Alaska. The system includes community clinics, sub-regional clinics, a regional hospital, dental services, behavioral health services, including substance abuse counseling and treatment, health promotion and disease prevention programs, and environmental health services.

YKHC is a Tribal Organization authorized by each the 58 federally recognized tribes in its service area to negotiate with the federal Indian Health Service to provide health care services under Title III of the Indian Self-Determination and Education Assistance Act of 1975. YKHC, along with 12 other Tribal Organizations, is a co-signer to the All-Alaska Tribal Health Compact, a consortium which negotiates annual funding agreements with the federal government to provide health care services to Alaska Natives and Native Americans throughout the state.

Community health aides provide village-based primary health care in 47 village clinics in the Yukon-Kuskokwim Delta. Health aides receive extensive training in acute, chronic and emergency care, have a five-tiered career ladder and are certified by a board operated by the Alaska Native Tribal Health Consortium. Health aides are nominated for training by their local village councils, and usually serve the villages where they grew up. The village health clinic is typically the first point of access to the YKHC health and behavioral health care system. Health aides consult with family medicine providers or specialists in Bethel and either treat patients locally or make referrals for individuals needing more comprehensive care.

The programmatic approach for children’s mental health services is core teams of licensed mental health professionals and behavioral health aides who are responsible for the provision of children’s mental health services in the rural villages of the Delta area. The core teams are modeled on the Community Health Aide Program, the rural health care program that uses indigenous community health aides (CHAs) and community health practitioners (CHPs), specially trained and certified individuals who offer health services, including preventive care and health screening services to small groups of individuals living in widely scattered villages in bush Alaska. More information about YKHC can be found at <http://www.ykhc.org>.

## NE Central Nebraska



Region 3 Behavioral Health Services (BHS) serves 22 counties in **Central** and **South Central Nebraska**. The service area covers 15,000 square miles and has a population of 223,000. Approximately half of the population in the Region 3 service area lives in three urban centers (Grand Island, Kearney, and Hastings). The remainder of Region 3 is rural.

With the support of the partners listed below and a federal grant, an effective service system, guided by system of care values and principles, has been created and sustained in Central Nebraska. These partners include:

- Region 3 BHS, one of six regional behavioral health authorities in Nebraska, governed by a board consisting of elected officials from the 22 counties served
- Nebraska Department of Health and Human Services (DHHS), Division of Behavioral Health Services (DBHS), the state mental health authority that contracts with each regional behavioral health authority and has been actively engaged in the work in Region 3
- Nebraska Department of Health and Human Services (DHHS), Central Service Area, Office of Protection and Safety, a state-administered agency that provides services in child welfare, juvenile justice, and developmental disabilities for 21 of the 22 counties in Region 3
- Families CARE, the family support and advocacy organization in Central Nebraska
- School districts and educational cooperatives including Grand Island Public Schools, Kearney Public Schools, and Educational Service Units 9 and 10.

Efforts to build a strong behavioral health service system for children and families in Central Nebraska began in 1989 when Region 3 hired a Child and Adolescent Services System Program (CASSP) Coordinator. Central Nebraska had the benefit of a five-year system of care grant from the federal Center for Mental Health Services, beginning in 1997. Prior to implementing a system of care in Central Nebraska, only 10% of the Region 3 BHS annual budget was allocated to children’s services, and four children’s services staff were employed. After receipt of the federal grant, the staff increased to approximately 48 FTEs related to child/family services. In fiscal year 2005, almost 50% of the Region 3 BHS budget was allocated for children’s services.

Within the system of care in Central Nebraska, there are several programs designed to serve children with differing needs, which are funded through collaborative financing strategies. These include:

- **Professional Partners (PP)** — Wraparound process for children who meet the definition for serious emotional disturbance and have other risk factors (implemented statewide)
- **Integrated Care Coordination (ICCU)** — Intensive care management based on principles of the wraparound process and family-centered practice, for children in state custody who have complex behavioral health needs and multiple agency involvement

- **Early Intensive Care Coordination (EICC)** — Similar to ICCU, but works with families in the child welfare system earlier, to prevent children from entering state custody
- **Family Advocacy/Support/Education and Youth Encouraging Support** — Both programs are offered by Central Nebraska’s family organization, Families CARE
- **Multisystemic Therapy (MST)** — Intensive, time-limited home-based treatment to help families of children with behavioral health needs make changes in their child’s environment
- **School Wraparound** — School-based wraparound approach to stabilize and maintain in the most normalized environment students who are experiencing emotional and behavioral challenges.

In fiscal year 2005, these six programs together served approximately 1,000 children and their families.

A case rate methodology, created in Central Nebraska by blending funding sources, serves as a primary funding strategy to support and sustain an intensive care management model, the work of Families CARE, a number of the services described above, and the system of care. Use of case rates has provided the flexibility to offer individualized care and develop new services. Cost savings have been reinvested in the child-serving system by providing technical assistance to replicate the program in other areas of the state and by expanding the population of children and families served in Central Nebraska. This case rate methodology is now used by five of the six regional behavioral health authorities in Nebraska.

Medicaid funds are not included in the case rate. The Nebraska DHHS/DBHS funds the public, *non-Medicaid* state mental health system. Region 3 BHS does not receive or manage Medicaid funds. Behavioral health services reimbursed by Medicaid are authorized by Magellan Behavioral Health Care, Inc., Nebraska’s statewide managed care administrative services organization (ASO), and reimbursements are made on a fee-for-service basis to providers. More information can be found at <http://www.region3.net>.

## Choices (IN Marion County, Indiana; OH Hamilton County, Ohio; MD Montgomery County and Baltimore City, Maryland)



**Choices, Inc.** is a nonprofit, community care management organization that coordinates services for individuals and families involved in one or more governmental systems. Choices uses the system of care philosophy and approach with wraparound values and blends them with managed care technologies to provide a wide range of services and supports to high-risk populations with multiple and complex service needs. Choices programs serve both children and adults; the core of each program is that services are family centered, community based, culturally competent, outcome driven, and fiscally accountable.



Choices, Inc. was incorporated in 1997 as a private, nonprofit entity. It was created by four **Marion County** community mental health centers to coordinate the Dawn Project, a collaborative effort among child welfare, education, juvenile justice and mental health agencies to serve youth with severe emotional disturbances and their families in Marion County, Indiana. Dawn began as a pilot and served its first ten youth in 1997. In 1999, a five-year federal grant from the Comprehensive Community Mental Health Services for Children and Their Families Program was awarded to the Dawn Project, enabling an increase in the number of children and families served, including an expansion in the target population to serve children at risk for out-of-home care, as well as support for the development of a family support and advocacy organization (Families Reaching for Rainbows) and evaluation activities.

Choices was conceived as a separate and independent entity to manage the Dawn system of care. Fulfilling the role of a “care management organization,” Choices provides the necessary administrative, financial, clinical, and technical support structure to support service delivery and manages the contracts

---

with the provider network that serves youth and their families. The responsibilities of Choices include: providing financial and clinical structure; providing training; organizing and maintaining a comprehensive provider network (including private providers); providing system accountability to the interagency consortium; managing community resources; creating community collaboration and partnerships; and collecting data on service utilization, outcomes, and costs. Choices now operates programs in several states that serve youth with serious emotional disorders — the Dawn Project in Marion County (Indianapolis), **Indiana**; Hamilton Choices in Hamilton County (Cincinnati), **Ohio**; and Maryland Choices in Montgomery County and Baltimore City, **Maryland**.

The goal of Dawn (and Choices programs for youth and families in Ohio and Maryland) is to improve services for youth with serious emotional disorders and to enable them to remain in their homes and communities by providing a system of care comprised of a network of individualized, coordinated, community-based services and supports, using managed care technologies. The managed care system is designed to serve youngsters with the most serious and complex disorders and needs across child-serving systems, those who typically are the most costly to serve and who are in residential care or at risk for residential placement. In essence, the design creates a separate “system of care carve-out” for this population. Dawn and Choices Ohio program are funded by case rates provided by the participating child-serving systems. The recently initiated program in Maryland is in the developmental stages; it is not as yet risk based and is not using the case rate approach at this time.

Over time, Choices has developed other services for high-need, complex populations, filling particular high-priority service gaps in the community. The Action Coalition to Ensure Stability (ACES) program serves adults who are homeless and who have co-occurring mental health and substance abuse disorders; Youth Emergency Services (YES) is a 24-hour mobile crisis service for abused and neglected children; and Back to Home serves runaway youth in the county. The common threads in all the programs operated by Choices include the use of managed care approaches, blended funding from participating agencies, individualized and flexible services, and care management.

In addition to its direct services, Choices has become a resource for technical assistance in Indiana. The Indiana Divisions of Mental Health and Family and Children began providing start-up resources in 2000 for the development of systems of care based on Dawn’s experience in other areas of the state. Choices has been a key technical assistance resource for these sites and, in 2002, was officially funded by the State as a technical assistance center (Technical Assistance Center for Systems of Care and Evidence-Based Practices for Children and Families) to provide assistance in developing similar community based systems of care throughout the state. More information about Choices can be found at: <http://www.choicesteam.org>.

## Wraparound Milwaukee **Wraparound Milwaukee**



**Wraparound Milwaukee** is a behavioral health carve-out, serving several subsets of children and youth with serious behavioral health challenges and their families in Milwaukee County, Wisconsin. Milwaukee County has a population of about 240,000 children under 18. The primary focus of Wraparound Milwaukee is on children who have serious emotional disorders and who are identified by the child welfare or juvenile justice system as being at risk for residential or correctional placement. Wraparound Milwaukee serves about 1,000 children a year over age five. (It does not serve the 0–5 population in general.) A combination of several state

and county agencies, including child welfare, Medicaid, juvenile probation services, and the county mental health agency, finance the system. Their dollars create, in effect, a pooled fund that supports Wraparound Milwaukee, which is a system of care administered by the Milwaukee County Behavioral Health Division in the County Department of Health and Human Services. Wraparound Milwaukee organizes an extensive provider network and utilizes care coordinators, who work within a wraparound, strengths-based approach. Wraparound Milwaukee involves families at all levels of the system and aggressively monitors quality and outcomes. It has an articulated values base that emphasizes: building on strengths to meet needs; one family-one plan of care; cost-effective community alternatives to residential placements and psychiatric hospitalization; increased parent choice and family independence; care for children in the context of their families; and unconditional care.

Wraparound Milwaukee operates as a special managed care entity under its contract with the state Medicaid program. It operates under a 1915 (a) waiver and a sole source contract between the state Medicaid agency and Milwaukee County, which allows it to blend funds from multiple child-serving systems. Governance is through the Milwaukee County Board of Supervisors.

Wraparound Milwaukee prefers to designate itself a “care management,” rather than managed care, entity, emphasizing a values base which it feels is more consistent with its public sector responsibilities than the term “managed care” may connote. The program, however, utilizes managed care technologies, including a management information system designed specifically for Wraparound Milwaukee, capitation and case rate financing, service authorization mechanisms, provider network development and management, accountability mechanisms, and utilization management, in addition to care management. More information about Wraparound Milwaukee can be found at: <http://www.milwaukeecounty.org/wraparoundmilwaukee>.

# Effective Financing Strategies Framework

## A Strategic Approach to Financing

A strategic approach to financing begins with system of care stakeholders answering two key questions: *Financing for whom?* and *Financing for what?*

### To answer these questions, system of care planners must achieve consensus on the following:

- Identify population(s) of focus, including the demographics, size, strengths and needs, current utilization patterns, and disparities and disproportionality in service use among the identified population(s)
- Agree on underlying values and intended outcomes
- Identify the services and supports and the desired practice model (for example, a strengths-based, individualized, culturally competent, family-driven and youth-guided practice approach) to achieve outcomes
- Determine how services and supports will be organized into a coherent system design
- Identify the administrative infrastructure needed to support the delivery system
- Cost out the system of care

Once these issues are addressed, then system builders can undertake a strategic financing analysis, which includes attention to the following:

- Identify the state and local agencies that spend dollars on behavioral health services and supports for the populations of focus
- Identify how much each agency spends and types of dollars spent (e.g., federal, state, local, tribal, etc.; also, entitlement, formula, discretionary, etc.)
- Identify resources that are untapped or under-utilized, such as Medicaid
- Identify utilization patterns and expenditures that are associated with high costs and/or poor outcomes
- Identify disparities and disproportionality in service access and utilization
- Determine the funding structures that will best support the system design, such as blended funding or risk-based financing
- Identify short and long-term financing strategies (for example, federal revenue maximization; redirection of spending from restrictive levels of care; taxpayer referenda, etc.)



## Developing a Strategic Financing Plan

The following seven areas must be addressed in a strategic financing plan for a system of care:

- I. Identifying spending and utilization patterns across agencies
- II. Realigning funding streams and structures
- III. Financing appropriate services and supports
- IV. Financing to support family and youth partnerships
- V. Financing to improve cultural and linguistic competence and reduce disparities in care
- VI. Financing to improve the workforce and provider network
- VII. Financing for accountability

This report describes each of these areas and provides examples of effective strategies related to each from the states and communities studied. While a given state or locality may not be implementing comprehensive strategies in every area, collectively, the states and communities studied provide a breadth of examples to illustrate effective financing approaches for systems of care, and all of the sites in the study sample have articulated in policy a commitment to system of care values and approaches.

**Hawaii** provides an example of a state that has developed a strategic financing plan as part of its overall strategic plan for children's mental health services.

### **HI** Hawaii

#### ***Developing a Strategic Financing Plan***

The legislature requires a four-year strategic plan for children's mental health services. A new plan was completed for the period 2007–2010, with seven priority areas:

- Decrease stigma and increase access to care
- Implement and monitor effectiveness of a comprehensive resource management program
- Implement a publicly accountable performance management program
- Implement and monitor a comprehensive practice development program
- Implement and monitor a strategic personnel management plan
- *Implement and monitor a strategic financial plan*
- Implement and monitor a strategic information technology program

Development of the strategic financing plan involved collection of information, including obtaining input from stakeholders, partner agencies, and others through meetings. The financing plan, as part of the larger strategic plan, builds on what is already in place and includes specification of thresholds/benchmarks and an emphasis on linking utilization, costs, and outcomes, financing incentives to drive system of care principles in provider agencies, and cost/quality efficiencies.

The broad goals of the financing plan are to demonstrate a diversity of sustainable funding streams, strengthen the expertise of the children's mental health branch (Child and Adolescent Mental Health Division [CAMHD]) in financial operations, achieve established thresholds for each funding source, demonstrate braided and blended funding programs with all child-serving agencies, and demonstrate routine financial reporting to the management team and community stakeholders. Specific goals are to:

- Strengthen Title XIX Medicaid billing practices
- Strengthen the Random Moments Studies billing
- Strengthen Title IV-E billing
- Strengthen braided and blended funding
- Maximize funding opportunities by pursuing federal and community grants
- Develop third-party billing agreements
- Implement routine financial reporting

For each goal, the plan delineates specific "initiatives," deliverable products, units responsible, and due dates. For example, for the goal on strengthening braided and blended funding, the plan specifies completing a review of all CAMHD agreements on joint funding, identifying possible options for other joint funding opportunities, and expanding the number of agreements for joint funding. The final product, a listing of joint funding MOAs, is to be completed by June 2008.



# I. Identification of Current Spending and Utilization Patterns Across Agencies

The identification of current spending and utilization patterns is an important first step in the development of a strategic financing plan for systems of care. This process enables a state, tribe, or community to understand how funds across all child-serving systems currently are being spent and for which children and families. It also assists in projecting expected utilization and costs, identifying potential resources, and planning accordingly.

## Financing Strategies Include:

**A. Determine and Track Utilization and Cost of Behavioral Health Services for a Defined Population**

**B. Identify the Types and Amounts of Funding for Behavioral Health Services Across Systems**

### A. Determine Expected Utilization and Cost and Track Utilization and Cost

*Arizona, Hawaii, New Jersey, Vermont, Choices and Central Nebraska* offer examples of determining and tracking utilization and costs for a variety of planning, rate setting, and accountability purposes.

#### **AZ** Arizona

##### ***Tracking Utilization and Cost for the Child Welfare Population***

The **Arizona** Department of Health Services, Division of Behavioral Health Services (ADHS/BHS), has worked with the state child welfare agency to identify utilization and costs associated with behavioral health services financed by the child welfare system that were being provided to Medicaid-eligible children and which could be covered by Medicaid instead of using all state general revenue dollars. This was part of a revenue maximization strategy. ADHS/BHS worked with child welfare and Medicaid actuaries to determine the cost of services to child welfare-involved children in licensed Level I out-of-home placements (i.e., secure and non-secure residential treatment centers and acute inpatient hospital care). The assumptions reflected that not all children would meet Medicaid criteria for placement (i.e., medical necessity criteria). The prior authorization criteria were expanded to allow for a decision to place or maintain a child in an out-of-home treatment setting if the child, along with having a mental health diagnosis, did not have a home to go to or the opportunity to obtain community-based services to maintain functioning. Specific dollars were allocated to Value Options

(VO), the contracted managed care organization in **Maricopa County**, to begin funding these out-of-home treatment services (as well as alternatives to out of home placement). Subsequently, additional funds were earmarked for child welfare-involved children to support their involvement in Level II and III placements (i.e., out of home placements less restrictive than residential treatment centers and inpatient hospital care, such as therapeutic foster care), as well as outpatient programs. As a result of this effort, the agencies identified a number of child welfare-involved children whom they felt should be in Medicaid-financed therapeutic foster care or in Medicaid-financed counseling services. The numbers of children were arrived at based on actual mental health services provided by child welfare for children eligible for Medicaid services.

The analyses undertaken with child welfare led to a revision upward in the capitation rate for child welfare-involved children (i.e., development of a risk-adjusted rate). Dollars were not shifted from child welfare as part of this process due to that system's experiencing an increase in children coming into custody; however, behavioral health received additional resources through the state budget process. Following these analyses, ADHS/BHS also expanded the definition of "urgent" as it relates to provision of crisis services. In the new definition, children who are removed from home by child welfare are considered to have "urgent behavioral health needs," requiring a 24-hour response by the behavioral health system to conduct an initial assessment. This expansion was made both to ensure timely response to children removed from home, and to intervene early to prevent the need for out-of-home therapeutic placements further down the road. While most of these children become state wards and thus eligible for Medicaid, at the time of the "urgent care" response, financial eligibility verification is not required.

Both statewide and in Maricopa County, about 60% of the foster care population was receiving behavioral health services through the managed care system at the time of the site visit. (That is now reportedly up to 75%.) In Maricopa, this is a sizeable increase over what had historically been a 30% foster care involvement rate. Increased access for children in child welfare is a goal of the Arizona reform.

The state develops a yearly utilization management report for children, ages 18 and under (and for 21 and under), that looks at units of service and financial expenditures. The largest percentage of dollars (36.4%) for children and youth is spent on what Arizona calls "support services," which includes case management, therapeutic foster care, respite care, family support, transportation, personal assistance, flex fund services, peer support, housing support services, and interpreter services.

## **HI** Hawaii

### ***Regular Tracking and Reporting of Utilization and Cost Trends***

Since 1997–98, the state children's mental health system in **Hawaii** has systematically tracked mental health service utilization to determine the amount of services to purchase from provider agencies. The Child and Adolescent Mental Health Division (CAMHD) produces a financial report on a regular basis (monthly and quarterly) that analyzes information regarding financial resources and expenditures. For example, the quarterly report specifies:

- How much Medicaid (Title XIX) revenue CAMHD receives per client/per month
- How much Special Fund revenue CAMHD received in the fiscal year and how much money remained in the Special Fund accounts (Medicaid capitation and fee for service, investment pool, Title IV-E)

- How much Title IV-E revenue CAMHD received
- Utilization trend for CAMHD emergency services, including 24 hour crisis telephone consultation, 24 hour mobile outreach, and crisis stabilization (average monthly cost per registered client)
- Utilization trends for CAMHD intensive services, including intensive in-home and Multisystemic Therapy–MST (average cost per client per month)
- Utilization trend for CAMHD residential services (average cost per registered client per month)
- Utilization trend for hospital-based residential care (average cost per registered client per month)
- Comparison of expenses from authorizations per unduplicated client among Family Guidance Centers
- How CAMHD operational expenses compare to quarterly allocations

Included in the financial report are charts showing operational expenses per month within General Funds, Special Fund (Title XIX), and federal and interdepartmental transfers (such as federal grants and Title IV-E funds). These expenses are broken down by service within categories including emergency services, intensive services, residential services, and other services (such as ancillary/flex services and respite services).

## **NJ** New Jersey

### ***Regular Tracking of Utilization and Cost Data***

**New Jersey's** Administrative Services Organization, called the Contracted Systems Administrator (CSA), authorizes, coordinates and tracks care for all children entering the system. Providers are paid using a single method and this allows for the maintenance of one electronic record of behavioral health care across systems that serve children. The CSA's ABSOLUTE Information System has the capacity to produce reliable cost and utilization data. Examples of the types of data that are tracked include:

- Number of referrals by source, location (county or CMO area), age, ethnicity and sex.
- Number of referrals screened (EPSDT), assessed, multi-system assessed by diagnosis, location, age, ethnicity, and sex.
- Number of referrals assigned to the CMOs statewide and by diagnosis, location, age, ethnicity, sex and referral source.
- Number of referrals and accepted children eligible for Medicaid, NJ Kidcare/Family care
- Number/Percent of children accepted in the Children's Initiative with service plan completed within required time frame by diagnosis, location, age, ethnicity and sex.
- Amount of dollars spent for children in the Children's Initiative by child, diagnosis, eligibility type (CMO, CSA care coordination), location, age, ethnicity, sex, service type
- Amount and type of service used (hours, days) per child by diagnosis, eligibility group, location, age, ethnicity, sex

- Timeliness of service authorization — Percent of service authorization decisions for continued stay in inpatient services made within 24 hours after receiving assessment information from a clinical provider or screening team (CSA UM system)
- Timeliness of service authorization — Percent of admission and continuation of care decisions for routine care for non-CMO children made within 5 working days after receiving a service request with all of the clinical information required by, and stated in, written CSA policy (CSA UM system)
- FSO involvement — Percent of CMO families referred to FSOs; percent of families in crisis referred to FSOs (CSA UM system)
- Restrictiveness of living environment — Percent and number of children who moved to a less restrictive living environment from entry to exit
- Readmission rate — Percent of children discharged from an inpatient facility readmitted within 7, 30, 90, and 180 days after discharge, stratified by age
- Functioning — Percent change in Strength and Needs Assessment scores (entry score, score at review period, exit score)
- Placement stability — Number of children unable to be maintained in current placement for emotional or behavioral reasons
- RTC length of stay — Percent change in RTC lengths of stay: · Per child · Per 100 children
- Adequacy of crisis management — Number of crisis screenings reported to the CSA: · Per child · Per 100 children
- Timeliness of crisis management follow-up — Percent of children discharged from crisis management that receive a service within three days
- Timely outpatient or community-based services follow-up to inpatient treatment — Percent of children discharged from inpatient care who receive outpatient or community-based services within seven days
- Coordination with the Medicaid HMO primary care physician (PCP) — Percent of children receiving psychotropic medications whose provider is actively coordinating with the Medicaid HMO PCP, excluding children without an assigned PCP.

**VT Vermont*****Tracking Utilization and Costs for Planning and Accountability***

**Vermont** routinely tracks utilization and costs associated with mental health and system of care services. The data are used for accountability functions and to document ongoing and changing needs in the community. They also provide basic information (presented to and reviewed by the legislature) that influences program and policy directions for children's behavioral health services. In addition to providing information for required fiscal reporting and monitoring by the state and local agencies, university partnerships also exist that utilize the data in special studies.

The designated community agencies report client and service information to the state Department of Mental Health on a monthly basis. These provider agencies have the responsibility for the development and maintenance of their respective management information systems. The data collected populate the state's mental health database that is used by the Department of Mental Health's research and statistics staff for tracking, analyzing, and reporting mental health information. A state-level, multi-stakeholder advisory group developed recommendations that guide these efforts.

An annual statistical report provides data on all aspects of mental health services in the state by various categories, including children's services. Regularly reported data on children's services cover, in the aggregate and by community service provider: age and gender; financial responsibility for service; diagnosis of clients served; length of stay; clinical intervention; individual, family, and group therapy; medication and medical support and consultation services; clinical assessment services; service planning and coordination; community supports; emergency/crisis assessment, support and referral; emergency/crisis beds; housing and home supports; and respite services.

The state also has reporting through the Vermont Performance Indicator Project (PIP) that issues brief reports on a weekly basis that provide information about different aspects of the behavioral healthcare system (<http://healthvermont.gov/mh/docs/pips/pip-reports.aspx>). These reports (PIPs) are available on the state's site and investigate indicators such as:

- Access to care
- Practice patterns
- Treatment outcomes
- Concerns of criminal justice involvement
- Employment
- Hospitalization

These reviews often examine the relationship of mental health services with other programs and state agencies. Cross-agency data analysis is facilitated by the use of a statistical methodology that provides unduplicated counts of the number of individuals served by multiple agencies, without reference to personally identifying information, thus protecting confidentiality and complying with HIPAA.

## **Choices** Choices

### ***Tracking Utilization and Cost for Case Rates***

**Choices** uses a method to determine utilization and cost for a defined population in order to develop their case rate and to determine and document the need for case rate adjustments. At present, Choices has an actuarial database on 1200 children. Data are analyzed by grouping children according to level of service need in order to correctly estimate utilization and costs for populations of youth from different referral sources and at different levels of need. The analytic process looks at cost of care, regardless of funding sources. It allows for utilization targets to be established for the various types and units of care within the case rate structure. Children are coded by referral source (such as child welfare or juvenile justice), and data are analyzed to determine what each population group would cost. The method involves computing the cost of particular services, the utilization of those services, plus the expected volume of services to be provided through Choices. This analysis determines if it is fiscally feasible to use a case rate approach or if fee-for-service must be used. Data are primarily from Choices utilization and cost data. Choices has had varying success obtaining utilization and cost data from the various agencies referring youth for services, but its own database produces reliable cost estimates.

## **NE** Central Nebraska

### ***Tracking Utilization and Expenditures for Case Rates***

The monthly case rate for children served by the Integrated Care Coordination Unit (ICCU) is \$2136/month. To track utilization and account for how these funds are spent, Region 3 Behavioral Health Services (BHS) prepares a monthly report that identifies, by child, direct service costs (including services provided, flex funds spent, and concrete expenditures such as transportation or rent) and non-direct service costs. This monthly report shows the extent to which the case rate was under-spent or over-spent for each child. From these reports on individual children/families, Region 3 BHS is able to track trends, such as: average cost per family, average cost of direct services, costs for youth who are in placement compared to costs for youth who are not in out-of-home placements, average monthly costs for different types of placements, and monthly associated non-service costs (including staff personnel costs). Yearly and monthly increases and decreases in expenditures by placement type also are tracked.

---

## B. Identify the Types and Amounts of Funding for Behavioral Health Services Across Systems (i.e., Map Cross System Funding)

This Strategy analyzes systematically expenditures for behavioral health services across systems and types of dollars spent and identifies under tapped funding sources.

**Central Nebraska** analyzed and “mapped” expenditures across child-serving systems to establish a case rate to support its system of care.

### **NE** Central Nebraska

#### ***Mapping Cross-System Funding to Establish a Case Rate***

When **Nebraska** proposed in 2000 to develop an individualized system of care for approximately 200 youth and their families in Central Nebraska, it had to identify funding sources for behavioral health services across child-serving systems. The target population was youth in state custody with intensive behavioral health needs who were placed in Agency-Based Foster Care and higher levels of care such as group homes, treatment foster care, and residential treatment. The state and the region believed that through partnering across systems and with the regional family organization, they could provide more appropriate care with better outcomes for families and youth at a lower cost. Nebraska used a case rate methodology as the financing structure to fund this system of care. To establish the case rate amount, the current cost of care (both the types and amounts of funding) for 201 youth was analyzed. This included all the child placement costs for each of the 201 children over a six-month period (1/00–6/00). It did not include treatment services that were funded by Medicaid. These treatment services remained available to the youth as needed, outside of the case rate. In 2000, the primary funding sources for the cost of care for these 200 children were state child welfare funds, juvenile services funds, and Title IV-E (federal). A small amount of “other” funds came from block grant funds, child care funds, reunification funds, and state-only funds.



---

## II. Realignment of Funding Streams and Structures

A multitude of funding streams at federal, state, and local levels can be drawn upon to support systems of care. However, the maze of funding streams that finance children’s mental health services must be better aligned, better coordinated, and, often, redirected, to provide individualized, flexible, home and community-based services and supports. Based on a careful analysis, a strategic financing plan “realigns” resources to develop a more coherent, effective, and efficient approach to financing the infrastructure and services that comprise systems of care. Such realignment involves using resources from multiple funding streams, maximizing the use of entitlement programs (such as Medicaid), redirecting and redeploying resources, and improving the management and coordination of resources.

### Financing Strategies Include:

- A. Utilize Diverse Funding Streams**
- B. Maximize Federal Entitlement Funding**
- C. Redirect Spending from “Deep-End” Placements to Home and Community-Based Services**
- D. Support a Locus of Accountability for Service, Cost, and Care Management for Children With Intensive Needs**
- E. Increase the Flexibility of State and/or Local Funding Streams and Budget Structures**
- F. Coordinate Cross-System Funding**
- G. Incorporate Mechanisms to Finance Services for Uninsured and Underinsured Children and their Families**



## A. Utilize Diverse Funding Streams

### **Strategies include:**

- Utilizing funding from multiple agencies to finance the services and supports within systems of care
- Pooling or blending funds
- Sharing costs for specific services and supports
- Utilizing special funding streams

### ► Utilizing Funding from Multiple Agencies to Finance Services and Supports

The sites studied use resources from multiple child-serving systems to finance services and supports. Resources from mental health, Medicaid, child welfare, juvenile justice, and education are used by all of the sites. Resources from the substance abuse, developmental disabilities, and health systems are included in the financing mix less frequently, but are included in some of the sites.

**Table 1** shows the extensive use of cross-system funding to contribute to financing a broad array of services and supports.

Source	Arizona	Hawaii	Vermont	Central Nebraska	Choices	Wraparound Milwaukee	New Jersey
Mental Health	X	X	X	X	X	X	X
Medicaid	X	X	X	X	X	X	X
Child Welfare	X	X	X	X	X	X	X
Juvenile Justice	X	X	X	X	X	X	X
Education	X	X	X	X	X	X	
Substance Abuse	X			X			X
Developmental Disability	X	X			X	X	
Health			X				

**Hawaii** and **Vermont** provide examples of how resources from multiple systems contribute to financing systems of care and their component services.

## HI Hawaii

### *Utilizing Resources from Multiple Systems*

Resources from multiple agencies/sources include:

- **Mental health general revenue** — Funds staff, services and supports not covered by Medicaid, payments to providers above the Medicaid rate (which “makes it or breaks it” for providers)
- **Medicaid** — through a carve-out operated by the Child and Adolescent Mental Health Division (CAMHD)’s children’s mental health system
- **Block Grant** — Funds screening and assessment of children in family court, screening and assessment of children in the child welfare system, statewide family organization, young adult support organization, early intervention and prevention, services for homeless children, etc.
- **Title IV-E** — Funds training, administrative costs, some costs for treatment of children in foster care system
- **SAMHSA Grants** — Fund system of care development, alternatives to seclusion and restraint, data infrastructure development. A grant from the Comprehensive Community Mental Health Services for Children and their Families Program funded system of care development in two areas on Oahu; a new grant from SAMHSA is financing system of care development for youth in transition to adulthood in one area of the state.
- **Education System** — Funds the cost of education in residential treatment programs
- **Office of Youth Services** — Funds an array of community-based services for children at risk for incarceration, including some community gang interventions, substance abuse services, sex offender services, sex abuse services, youth development, and some cost sharing on an individual case basis
- **Developmental Disabilities** — Provides cost sharing as needed on an individual case basis

## VT Vermont

### *Utilizing Resources from Multiple Systems*

The Department of Mental Health, the Department of Education, and the Department for Children and Families are the principal partners and funding sources, with Medicaid making the largest contribution. **Vermont** Health Department data show that Medicaid had responsibility for at least some of the cost for 77% of the children’s behavioral health services provided in 2005. In Chittenden County, for example, Howard Center (the designated local service agency) estimated that Medicaid would contribute about 45% to the agency’s total budget for children’s services funding in 2007. This does not include mental health services to children in residential care, which is listed separately and covered by a per diem that includes but does not break out mental health services. Education contributes funding in several ways, including support for an approved Vermont Department of Education school under the auspices of the local designated agency that provides a therapeutic, regional educational program to meet the needs of junior and early high school age students experiencing serious emotional, social, behavioral, and academic problems. Referring school districts pay tuition for students placed in the program directly to the agency operating the school. The school utilizes a portion of this revenue as match to bill Medicaid for treatment-related services.

In financing early childhood mental health services, funding streams come from Part C of IDEA, Medicaid/S-CHIP, mental health grants, maternal and child health, child and family services funding (Head Start), private insurance, and family contributions. Funding from these resources finance a mix of services through a variety of providers and programs, including early intervention centers, shelters with child care, substance abuse treatment programs, etc.

State agency partners contribute some of their general fund allotment to the mental health agency in order to draw down federal Medicaid funds to pay for services. This approach can be seen in schools with school-based services, as well as with mental health services provided in homes and at community agencies. School-based services use Medicaid, education dollars, and other grant and discretionary funds for behavioral health screenings, counseling services, and training. EPSDT is administered through the health department, which contracts with school districts. Schools pay nurses and guidance counselors for the work, which allows the early detection of behavioral health issues.

Funding is also shared between mental health, the Division of Vocational Rehabilitation (in the Department for Children and Families) and the Department of Corrections to fund the JOBS program for youth at high risk as they transition to adult life.

In addition, the creation of a child's Coordinated Services Plan under Vermont's Act 264 pulls together whatever public and private providers and supportive individuals are relevant to a specific child and family to assess needs, to determine desired goals, and to plan who can provide those services and supports as well as who can pay for them.

## ► Pool or Blend Funds

**Central Nebraska** blends funds from multiple systems to create case rates to finance services. **Choices** and **Wraparound Milwaukee** also provide examples of braiding or blending funds to finance services and use of case rates. **Vermont**, through its new Medicaid waiver, is working to establish a pool of resources from multiple agencies to finance services for children with multiple and serious needs.

### **NE** Central Nebraska

#### ***Blending Funds through Case Rates***

In **Central Nebraska**, a case rate methodology, created with blended funding sources, serves as a primary funding strategy to support and sustain an intensive care management model, the work of the family support organization, a number of services and its system of care. Funds were blended to achieve the Integrated Care Coordination Unit (ICCU) case rate of \$2,136.53 per child per month. The case rate was established in 2000 after an analysis of placement costs for 200 children in state custody. The primary funding sources for these children were state child welfare funds, juvenile services funds, and Title IV-E (federal). A small amount of "other" funds came from block grants, child care funds, reunification funds and state-only funding. Currently, the ICCU case rate consists of state funding (child welfare, state general funds and some juvenile justice funding) and federal funding (Title IV-E).

The case rate for the Professional Partner Program (PPP), a wraparound program for children with serious emotional disorders, is set by the state Division of Behavioral Health based on regional costs. Funding sources are 89.7% state general funds and 10.3% federal mental health block grant funds. The majority of placement costs are *not* included in the \$698.75/child/month case rate; however, some service costs are paid through flex funds included in the case rate.

Neither of these case rates includes funding for treatment services. Funding from Medicaid, Kid Connect (the Nebraska S-CHIP program) and third-party reimbursement are used to pay for treatment services. While these funds are not within the control of Region 3 Behavioral Health Services (BHS), care coordinators and clinicians on the child and family teams work closely with Magellan (the administrative services organization for Medicaid) to fund the plan of care for each child.

Use of case rates has provided the flexibility to offer individualized care and develop new programs. This case rate methodology has been expanded to other areas of the state and is now used by five of the six regional behavioral health authorities in Nebraska.

## **Choices** **Choices**

### ***Blending or Braiding Funds from Multiple Systems***

In the areas currently served by **Choices**, various child-serving agencies contribute to the financing of care. The method of contributing, however, varies. In **Indiana**, each referring agency — child welfare, juvenile justice, and education — pays the case rate for each child referred for care, which could be characterized as a braided funding approach. The state’s mental health managed care system adds to the case rate paid by the referring agency for each child served in Indiana as part of its contribution to building Indianapolis’ system of care; it amounts to a 4% contribution. Additionally, the state’s mental health system pays the match for the Medicaid Rehabilitation Option, which amounts to another \$1 million contribution in billable services.

In **Ohio**, the participating agencies include child welfare, mental health and addictions, juvenile justice, and developmental disabilities. Each participating agency contributes a negotiated percentage amount of funding into a large pot of money, which is then blended by Choices. A “shareholder” referral system is used whereby a committee with cross-agency representation makes the decisions about youth who are referred to services based on eligibility criteria.

Choices also bills Medicaid for covered services for eligible youth. The case rates cover all services and supports that are not covered by Medicaid. In both Indiana and Ohio, the case rate dollars can be used to purchase any services that are included in the individualized service plan that is developed by the child and family team. The care plan drives the service delivery process, and any type of service or support included in the service plan is considered “authorized.”

## Wraparound Milwaukee **Wraparound Milwaukee**

### ***Blending Funds from Multiple Systems, Including Medicaid, Through Case Rates and Capitation***

**Wraparound Milwaukee** blends several funding streams: Medicaid dollars through a capitation from the state Medicaid agency of \$1,589 per member per month (pmpm); child welfare dollars through a case rate of \$3,900 pmpm; mental health block grant dollars; and both contract dollars and case rate dollars from the juvenile justice system.

Blending of funds for youth in the delinquency system is based on two target populations. These include youth whom the delinquency program would otherwise place and fund in residential treatment centers (about 350 youth), for whom Wraparound Milwaukee receives \$8.2 million in fixed funds from the budget that Delinquency and Court Services would otherwise use to pay for this level of care. The second target group is youth who would otherwise be committed to the state Department for Corrections for placement in a locked correctional facility (about 45 youth). Delinquency and Court Services pays Wraparound Milwaukee a case rate of \$3,500 per youth per month for these youth. If these youth were placed in a correctional facility, Milwaukee County would be charged about \$7,000 per youth per month for the cost of these placements under the state's charge-back mechanism to counties. These youth are diverted to Wraparound Milwaukee through a "Stayed State Order" versus a direct County order. All of these youth must be Medicaid-eligible and have a serious emotional disorder.

As noted, because the county juvenile justice system gets charged the cost of correctional placements, which run about \$7,000 pmpm, it has an incentive to utilize Wraparound Milwaukee, whose costs run about \$3,500 pmpm for the juvenile justice population. Similarly, because both child welfare and juvenile justice, prior to Wraparound Milwaukee, paid for residential treatment, both systems have incentives to utilize Wraparound Milwaukee, which delivers lower per member per month costs and better outcomes. The child welfare and juvenile justice systems share 50/50 the cost of youth with dual delinquency and dependency court orders.

In addition to these funding streams, Wraparound Milwaukee operates the County's mobile crisis program for county youth (Mobile Urgent Treatment Team—MUTT), which also is supported by dollars blended from multiple funding streams. Every child enrolled in Wraparound Milwaukee automatically is eligible for services from MUTT, and other families in the county may use it for a crisis related to a child. The child welfare system and Milwaukee Public Schools wanted an enhanced, dedicated mobile crisis team to provide crisis intervention and on-going (30-day) follow-up. Each provides annual funding of \$450,000 to support this enhanced capacity. Wraparound Milwaukee also is able to bill Medicaid for this service under Wisconsin's crisis benefit. This includes the MUTT crisis team; a portion of care managers' time spent preventing or ameliorating crises; 60% of the cost of crisis placement in a group home, foster home or residential treatment facility; and the cost of 1:1 crisis stabilizers in the home. Since Wraparound can recover a percentage of its costs by billing Medicaid, it is able to add about \$180,000 to the Milwaukee Public Schools enhanced capacity and about \$200,000 to the child welfare capacity. Wraparound's total Medicaid crisis reimbursement was nearly \$6 million in 2006.

In addition to these funding streams, the developmental disabilities system gives Wraparound Milwaukee five of its Home and Community Based Waiver slots. There is no county tax levy for mental health services. The Wraparound Milwaukee MIS system interfaces with both the state child welfare (SACWIS) and state Medicaid data systems to keep track of Medicaid and Title IV-E expenditures for federal claiming and audit purposes.

**VT Vermont**

***Exploring a Medicaid Waiver to Pool Resources for Children with Multiple Needs***

The state negotiated a first of its kind 1115 (a) Medicaid waiver with the federal government in 2005. Called the Global Commitment Waiver, it is designed to reform the state’s Medicaid program by helping both the state and federal governments manage Medicaid expenditures at a sustainable level over the five year pilot period. Under this waiver, the state accepts a cap on its Medicaid funding in exchange for greater flexibility in how it spends its Medicaid funds, and with the increased flexibility, the state hopes to provide more individualized services and to produce better outcomes. Related to this, **Vermont’s** child-serving partner agencies identified difficulties in funding services for children with multiple, severe needs as a high priority. Under the authority of the Global Commitment Medicaid waiver, the state is working to establish a mental health funding resource that would create a pool of resources funded by several agencies for services and supports for children with multiple and serious needs. Contributing agencies are likely to include: mental health, child welfare, education, health and substance abuse, developmental services, and juvenile justice.

**► Share Costs for Specific Services and Supports**

**Arizona, Hawaii, Vermont, Central Nebraska,** and **Wraparound Milwaukee** provide examples of sharing costs for specific services.

**AZ Arizona**

***Sharing Funding Responsibility for Specific Services***

The **Arizona** Department of Health Services, Division of Behavioral Health Services (ADHS/BHS) partners with other systems to share funding responsibility for certain programs. For example, the managed care system uses only therapeutic foster homes licensed by child welfare for the Regional Behavioral Health Authority (RBHA) networks (with the exception that tribes may license homes), which enables Title IV-E funds to be used for room and board costs for eligible children. Similarly, all child welfare in-home providers must be Medicaid providers, providing a foundation for a common network of service providers between these two systems. The managed care system also provides behavioral health services to about 78% of adult family members with substance abuse problems who are involved in child welfare.



**HI** Hawaii

***Sharing Costs with Child Welfare, Juvenile Justice, and Education***

Cost sharing is used in financing several of *Hawaii's* services. Cross-agency relationships are considered key to accomplishing these approaches and take significant time to develop. Examples of cost sharing include:

- Cost sharing with the child welfare system of therapeutic foster home costs to allow permanent placements for troubled youth, maintaining them in a stable home with a reduced cost of services over time
- Cost sharing with the juvenile justice system to provide a psychologist with Block Grant funds and to place a mental health care coordinator at the detention facility to prevent unnecessary incarceration
- Mental health system built a system of school-based services and then transferred the funding legislatively to the education system. The Department of Education (DOE) now manages these services on a statewide basis and has developed a system to bill Medicaid for mental health services. The Child and Adolescent Mental Health Division (CAMHD) provides more intensive services based on identified needs.

**VT** Vermont

***Sharing Costs for Specific Services***

Under *Vermont's* Act 264 and in practice, agencies share costs for specific services and supports. A child's Coordinated Service Plan is legally an addendum to other state and federally mandated plans (e.g., educational 504 plan or Individualized Education Plan, mental health Individual Plan of Care, child welfare case plan). The Plan drives services and funds required. Typically, each of the partner agencies (mental health, education, children and families, developmental disabilities, etc.) funds those services for which it is responsible either through memoranda of understanding with the local lead agency or directly, depending on the service and delivery arrangement. Funds are also transferred across agencies for specific services (e.g., crisis services, respite) and state agency partners contribute funds from their general fund allotment to the mental health agency in order to draw down Medicaid funds to pay for service. Transfers include those especially aimed at building system capacity. For example, the Department for Children and Families has provided funds to the Department of Mental Health for preventive and early intervention services with children and families to avert placement into state care and to expand capacity in the mental health system. The focused effort to improve system response to families approaching or in crisis by blending planning and funding from the Department of Mental Health and the Department for Children and Families has significantly reduced the number of youth entering custody under emergency CHINS (Children in Need of Supervision) court orders.

Another example involves local education agencies (LEAs) and local mental health Designated Agencies, which are co-funding the Success Beyond Six initiative. This strategy uses state general funds from LEAs as match to draw down mental health Medicaid funds through a contracting process. The LEA specifies what types and amount of services it wants for its Medicaid eligible students, such as a full- or part-time therapist to conduct groups on social skills or anger management, individual behavior intervention specialists, or home school coordinators. The mental health agency hires and supervises appropriately trained and credentialed staff to provide the services.

## **NE** Central Nebraska *Sharing Costs for Specific Services*

In addition to blending funds to achieve case rates, **Central Nebraska** shares costs across agencies, systems, and programs:

Integrated Care Coordination (ICCU) — Care coordinators from child welfare and mental health are co-located at ICCU sites to facilitate the integration of services and to share resources. For example, the Region 3 Behavioral Health Services (BHS) and the Central Area Office of Protection and Safety (child welfare) share the cost for personnel, space, supplies, and furniture for the Integrated Care Coordination Unit (ICCU). Each agency employs half of the care coordinators in ICCU and divides the cost of supervision. Even though the care coordinators are employed by different agencies, ICCU directors indicated that the only way to tell the difference is to know who signs the pay check.

- **Multisystemic Therapy (MST)** — The development of MST was funded by the federal system of care grant. A variety of funding sources cover the actual service costs. MST providers are paid a case rate based on outcomes achieved with each youth/family. Within the case rate, Medicaid pays for intensive outpatient services. If the provider does not receive the maximum case rate earned, Region 3 BHS pays the remainder, after all other appropriate parties have been billed and payment has been received. Region 3 BHS also purchases MST for families who do not have another payer source.
- **School Wraparound** — Although there is no exchange of funds between the local school system and Region 3 BHS, they share the costs for space and personnel. The schools pay for the educational facilitator. Region 3 BHS pays for the professional partner (family facilitator). These two facilitators become a school wraparound team, work together with each child and family team, and are housed in the same office.
- **Family Support and Advocacy** — Families CARE shares office space and cars with the Grand Island Health and Human Services Office.



---

## **Wraparound Milwaukee** **Wraparound Milwaukee**

### ***Sharing Costs for Crisis Services***

Mental health, child welfare and Milwaukee Public Schools co-finance mobile crisis services, which also are billable to Medicaid for Medicaid-eligible children. **Wraparound Milwaukee** operates the County's mobile crisis program for county youth (Mobile Urgent Treatment Team [MUTT]). Every child enrolled in Wraparound Milwaukee automatically is eligible for services from MUTT, and other families in the county may use it for a crisis related to a child. The child welfare system and Milwaukee Public Schools wanted an enhanced, dedicated mobile crisis team to provide crisis intervention and on-going (30-day) follow-up. Each provides funding of \$450,000 to support this enhanced capacity. Wraparound Milwaukee also is able to bill Medicaid for this service under Wisconsin's crisis benefit. This includes the MUTT crisis team; a portion of care managers' time spent preventing or ameliorating crises; 60% of the cost of crisis placement in a group home, foster home or residential treatment facility; and the cost of 1:1 crisis stabilizers in the home. Since Wraparound Milwaukee can recover a percentage of its costs by billing Medicaid, it is able to add about \$180,000 to the Milwaukee Public Schools enhanced capacity and about \$200,000 to the child welfare capacity through Medicaid billings. Wraparound Milwaukee's total Medicaid crisis reimbursement was nearly \$6 million in 2006. In addition to co-financing for MUTT, juvenile justice and child welfare co-finance crisis residential services, certain costs of which also can be billed to Medicaid.

## B. Maximize Federal Entitlement Funding

### *Strategies include:*

- Maximizing eligibility and/or enrollment for Medicaid and S-CHIP
- Covering a broad array of services and supports under Medicaid
- Using multiple Medicaid options and strategies
- Using Medicaid in lieu of state-only general funds
- Generating Medicaid match

### ► Maximizing Eligibility and/or Enrollment for Medicaid and S-CHIP

*Arizona, Hawaii,* and *Vermont* and *Bethel, Alaska* have worked to maximize eligibility and enrollment for the state Medicaid and S-CHIP programs.

#### **AZ** Arizona

### *Improving Medicaid Eligibility Determination for Youth in Juvenile Justice*

The *Arizona* Department of Health Services (ADHS) and juvenile justice have collaborated to improve Medicaid eligibility determination for youth in juvenile justice as a result of state legislation mandating that the juvenile justice system implement a system to track the number of youth who are Medicaid eligible. The juvenile justice system is looking at the Medicaid eligibility of every youth coming into detention or otherwise involved with the court, and probation workers have to check eligibility. This work is supported by both a telephone hook-up to the state Medicaid agency and a website. The legislature also allocated funds to the juvenile justice system for mental health services for non-Medicaid eligible youth, and juvenile justice has been able to spend more on non-Medicaid youth because of doing a better job identifying those who are eligible for Medicaid. In Maricopa County, the juvenile justice system has a goal of linking every Medicaid-eligible youth in need of mental health services to a Comprehensive Service Provider (CSP), which is the behavioral health system's core service provider. ADHS, Division of Behavioral Health Services (BHS), developed a technical assistance document focused on Medicaid eligibility for youth involved in juvenile justice, which is available on their website. (See: <http://www.azdhs.gov/bhs/guidance/cid.pdf>) Value Options co-located staff in juvenile detention to ensure that youth are enrolled with the Regional Behavioral Health Authority (RBHA), if eligible, are enrolled with a CSP, and to work with detention to offer a community placement to the courts. This is a strategy to prevent youngsters involved in juvenile justice from losing their Medicaid eligibility and to divert youth from deep-end services.

## **HI** Hawaii and **Vt** Vermont

### **High Eligibility Levels for Medicaid and S-CHIP**

- In **Hawaii**, Medicaid eligibility level is 300% of the federal poverty level. S-CHIP is a Medicaid expansion and covers additional children. Higher levels of eligibility are accomplished by allowing individuals to buy into the Medicaid program.
- In **Vermont**, Medicaid and S-CHIP are highly integrated. Medicaid covers uninsured children up to 223% of the federal poverty level, and underinsured children up to 300%. S-CHIP covers uninsured children between 225% and 300% of the federal poverty level. The application process is the same for both programs, and the benefit package and delivery systems also are the same. Vermont began providing health care coverage to children through age 20 under the Medicaid program in 1967. “Dr. Dynasaur” was created in 1989 as a state-funded program for pregnant women and children through age 6, who did not have health insurance and did not qualify for traditional Medicaid. In 1992, “Dr. Dynasaur” was integrated into Medicaid and expanded to children through up to age 18. It later incorporated the S-CHIP program. All children (and pregnant women) are covered under the “Dr. Dynasaur” program, regardless of whether they are Medicaid or S-CHIP enrolled. Vermont’s Medicaid program now includes “Dr. Dynasaur,” traditional Medicaid, the Vermont Health Access Plan (VHAP), VHAP Managed Care, Medicaid Managed Care, VHAP Pharmacy and VScript. Together with private insurance coverage, these programs provide almost universal health coverage for Vermont children.

## **AK** Bethel, Alaska

### **Implementing Outreach to Maximize Enrollment**

Medicaid services for every American Indian and **Alaska** Native are reimbursed to the state with 100% federal match dollars if the services are provided through a Tribal provider. Additionally, services rendered to Medicaid-enrolled children by the Yukon Kuskokwim Health Corporation (YKHC) that are included in their children’s agreement are reimbursed at full cost through an annual cost settlement process.

About 80–85% of youth are Medicaid eligible, but there are significant barriers to enrollment as documented in the December 2003 study, *American Indian and Alaska Native Eligibility and Enrollment in Medicaid, S-CHIP and Medicare*, funded by the federal Centers for Medicare and Medicaid Services (CMS). The barriers include general distrust of government, the perception of federal responsibility for health care for the American Indian and Alaska Native population as an entitlement to care through the Indian Health Service, transportation, distance, lack of knowledge about the programs, language, literacy and other cultural barriers. For these reasons, YKHC implemented outreach efforts that specifically target enrollment in Medicaid. Children are eligible for Medicaid for six-month periods at a time (except disabled children and newborns eligible for one year), so an additional challenge for the Delta is the seasonal activities for subsistence during which families travel to remote camps and have no phone or mail services for months at a time, making it impossible to reach families for eligibility re-determination. Alaska’s eligibility level for S-CHIP is 185% of the 2004 Federal Poverty Level.

## ► Cover a Broad Array of Services and Supports Under Medicaid

All of the states included in the sample cover a broad array of services and supports under their Medicaid programs. **Arizona, Hawaii, New Jersey, Vermont,** and **Alaska** are examples of states that have included an extensive list of services in their state Medicaid plans, including services such as respite, family and peer support, supported employment, therapeutic foster care, one-to-one personal care, skills training, intensive in-home services, and many others. Alaska has developed a mechanism to cover traditional Native healing services under its state Medicaid program.

### **AZ** Arizona

#### ***Including a Broad Array of Services in the State Medicaid Plan***

In connection with the JK settlement agreement, **Arizona** Department of Health Services, Division of Behavioral Health Services (ADHS/BHS) and the state Medicaid agency expanded covered services and revised licensure rules and rates. Prior to JK, the Medicaid benefit was fairly traditional, covering counseling, medication management, day treatment, partial hospitalization, inpatient, residential treatment and therapeutic group homes. With JK, the state deliberately tried to get coverage for a very broad array of services and supports from wraparound to community-based to medical, either by adding new covered services or by changing definitions for already covered services. The following new services were added: sub-acute step down, respite, case management, peer and family support, supported employment, and therapeutic foster care. Also, a new provider type — community service agencies — was created to provide rehabilitation services so that these services would not have to be provided solely by clinics or hospitals. The definition of day treatment was expanded to include a less intensive version, such as after school, which can be provided as a rehab service by behavioral health technicians and can be provided in schools. At the same time, a more intensive day program with a medical component was added for children who are medically fragile, and the state added a 1:1 personal care provider. The state removed limitations on place of service so that services can be provided in any location. The state also added general revenue funds to cover non-Medicaid services, such as traditional Native healing and acupuncture for substance abuse.

In addition to expanding the array of covered services, in an effort to change practice, the state also increased rates so that out-of-office rates are higher than office-based rates. Reportedly, the state Medicaid staff that worked with BHS had a good understanding of service delivery for children's behavioral health (many came from the service side), and both agencies worked cooperatively. Also, the two agencies did a lot of training on the new array of covered services. Arizona's list of services covered under Medicaid include:

- Behavioral counseling and therapy
- Assessment, evaluation and screening
- Skills training and development and psychosocial rehabilitation skills training
- Cognitive rehabilitation
- Behavioral health prevention/promotion education and medication training and support services
- Psychoeducational services and ongoing support to maintain employment
- Medication services
- Laboratory, radiology and medical imaging

- Medical management
- Case management
- Personal care services
- Home care training (Family support)
- Self-help/peer services (Peer support)
- Therapeutic foster care
- Unskilled respite care
- Supported housing
- Sign language or oral interpretive services
- Non medically necessary services (flex fund services)
- Transportation
- Mobile crisis intervention
- Crisis stabilization
- Telephone crisis intervention
- Hospital
- Subacute facility
- Residential treatment center
- Behavioral health short-term residential, without room and board
- Behavioral health long term residential (non medical, non acute), without room and board
- Supervised behavioral health day treatment and day programs
- Therapeutic behavioral health services and day programs
- Community psychiatric supportive treatment and medical day programs
- Prevention services

For a complete description of Arizona’s covered services, see the state’s *Covered Behavioral Health Services Guide*, available at: [http://www.azdhs.gov/bhs/bhs\\_gde.pdf](http://www.azdhs.gov/bhs/bhs_gde.pdf). Appendix B2 to the guide describes provider types and fee for service rate guidance, available at: [http://www.azdhs.gov/bhs/app\\_b2.pdf](http://www.azdhs.gov/bhs/app_b2.pdf).

## HI Hawaii

### *Including a Broad Array of Services in the State Medicaid Plan*

The state Medicaid plan covers a broad array of mental health services and supports. Modification of the state Medicaid plan to add the broad array of services provided through the Child and Adolescent Mental Health Division (CAMHD) system (the Medicaid carve-out) was accomplished by developing a strong relationship with the leadership of the Medicaid agency through frequent face-to-face meetings. CAMHD's efforts have included identifying services to be added to the Medicaid plan; proposing definitions, rates, and credentialing status; and identifying fiscal incentives for the state (such as how much is currently being spent using state resources and any savings that can be realized). Under the category of Community Mental Health Rehabilitative Services, a range of services is covered to promote the "maximum reduction and/or restoration of a recipient to his/her best possible functional level relevant to their diagnosis of mental illness and/or abuse of drugs/alcohol." Covered services include the following:

- **Crisis management** — telephone hotline, face to face, and mobile crisis assessment and intervention in a variety of community settings
- **Crisis residential services** — short-term interventions to address a crisis and avert or delay the need for acute psychiatric inpatient services or similar levels of care
- **Biopsychosocial rehabilitative programs** — therapeutic day rehabilitative social skill building service
- **Intensive family intervention** — time-limited interventions to stabilize the client and family and promote reunification or prevent the utilization of out-of-home therapeutic resources, including Multisystemic Therapy (MST) and intensive in-home services
- **Therapeutic living supports** — therapeutic services (not room and board) in group homes
- **Therapeutic foster care supports** — therapeutic services (not room and board) in therapeutic foster home settings
- **Intensive outpatient hospital services** — to provide stabilization of psychiatric impairments and enable individuals to reside in the community or return to the community from a more restrictive setting (partial hospitalization)
- **Assertive community treatment** — intensive community rehabilitation service including a range of therapeutic and supportive interventions

At the time of the site visit, a number of additional services were being added to the state Medicaid plan for fiscal year 2007, with draft definitions developed. These have not as yet been approved, but include:

- **Peer supports** — services provided by peer counselors to youth, young adults, and their families to promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills
- **Parent (skills) training** — teaching evidence-based behavior management interventions to parents or caregivers in order to develop effective parenting skills to promote more competencies in the parent/caregiver's ability to manage the child's behavior
- **Intensive outpatient substance abuse independent living** — a package of services designed to assist youth and young adults with co-occurring mental health and substance abuse issues to enable them to remain in their home environments while receiving treatment

- **Community hospital crisis stabilization** — short-term crisis intervention to youth or young adults experiencing mental health crises as a closely supervised, structured alternative to or diversion from acute psychiatric hospitalization
- **Multisystemic Therapy (MST)** — an intensive family and community-based model of treatment for youth and their families who are at risk of out-of-home placement, based on evidence-based interventions that target specific behaviors with individualized behavioral interventions (currently covered under intensive family interventions)
- **Multidimensional Treatment Foster Care** (could go under therapeutic foster care supports)
- **Functional Family Therapy** — an evidence-based family treatment system provided in a home or clinic setting with the goal of engaging all family members and targeting and changing specific risk behaviors
- **Community Based Clinical Detox** — a short-term, 24 hour clinically managed detoxification service delivered with medical and nursing support in a secure residential facility

Consideration is being given to transferring responsibility for acute psychiatric hospitalization and assessment and outpatient services from the Quest Health Plans to the CAMHD system. Effective 2/07, CAMHD will be responsible for all services including acute and outpatient services for youth enrolled in the CAMHD carve-out.

## **NJ** New Jersey

### ***Including a Broad Array of Services in the State Medicaid Plan***

In order to achieve a more expansive benefit design, the state expanded services covered under Medicaid through the Rehabilitation Service Option. The services now covered under Medicaid include non traditional and traditional services. These services include: assessment, mobile crisis/emergency services, group home care, treatment homes/therapeutic foster care, intensive face-to-face care management, wraparound, out-of-home crisis stabilization, intensive in-home services, behavioral assistance, wraparound services, and family-to-family support.

## **VT** Vermont

### ***Including a Broad Array of Services in the State Medicaid Plan***

Medicaid is the principal payer for behavioral health and system of care services. The state has sought through its Medicaid plan, EPSDT, S-CHIP/"Dr. Dynasaur" and waivers to fund an array of prevention, treatment and support services that are provided to children in a variety of settings. Medicaid covers the following categories and services:

- Inpatient hospital services prescribed by a physician, including diagnostic interviews with immediate family members and psychotherapy if a component of the treatment plan; most of the child screenings by community mental health centers prior to emergency hospitalization



- Outpatient hospital clinic (including rural health center and Federally Qualified Health Center) services — mental health services, directed by a physician or psychologist that would be covered if provided in another setting
- Evaluation, diagnosis and treatment services from licensed independently practicing psychologists
- Inpatient psychiatric facility services, crisis diversion beds, inpatient hospitalization, residential treatment, therapeutic foster care — must be physician prescribed, have interagency team certification that beneficiary cannot be treated effectively in the community, and prior authorization by external review
- Mental health clinic evaluation, diagnostic and treatment services — psychotherapy, group therapy, day treatment, prescribed drugs for treatment and prevention, emergency care services — that are specified in a treatment plan directed by or formulated with physician input
- Rehabilitation services provided by qualified professional staff in designated community mental health centers that cover services listed in the preceding plus specialized rehab services including basic living skills, social skills, and counseling, as specified in the treatment plan
- School health services — mental health assessment and evaluation, medical consultation, mental health counseling, developmental and assistive therapy, case management — ordered by an individual education plan (IEP) or individualized family service plan for special education students
- Child sexual abuse and juvenile sex offender treatment services — individual, group, and client-centered family counseling; care coordination, clinical review and consultation
- Intensive family-based services — family-focused, in-home treatment services that include crisis intervention, individual and family counseling, basic living skills and care coordination
- Targeted case management services — assessment, case plan development, monitoring and follow-up services, and discharge planning
- Home and community-based waiver services — case management, respite care, residential and day services
- Transportation

### **AK** Bethel, Alaska

#### ***Including a Broad Array of Services in the State Medicaid Plan***

*Alaska's* state Medicaid plan covers a broad array of mental health services. The Yukon Kuskokwim Health Corporation (YKHC) provides these services and then bills Medicaid for reimbursement. The Medicaid reimbursable services include: assessment and evaluation; individual, group, and family therapy; home-based services; day treatment; crisis services; psychiatric inpatient care; group homes; residential treatment; case management; school-based services; respite; and behavior management skills development. For Alaskan Native populations, specialized traditional Native healing services are reimbursed by Medicaid. YKHC has developed a crosswalk that places traditional Native healing services into the appropriate "western" slot. YKHC bills for the Medicaid service, and Medicaid pays for the "western" service.

## ► Use Multiple Medicaid Options and Strategies

The sites studied have maximized Medicaid financing of behavioral health services for children by taking advantage of the multiple options available to states under the Medicaid program, including the clinic and rehabilitation options, targeted case management, EPSDT, and several different types of waivers. **Table 2** demonstrates the extensive use of multiple options.

	Arizona	Hawaii	Vermont	Nebraska	New Jersey
Clinic Option	X	X	X	X	X
Rehab Option	X	X	X	X	X
Targeted Case Management		X	X	X	X
Psych Under 21	X	X	X	X	X
EPSDT	X	X	X	X	X
Katie Becket (TEFRA)			X	X	
H & CB Waiver (1915c)	DD*	DD*	X**	DD*	DD*
1915b Waiver			X		
1115 Waiver	X	X	X***		
Family of One	X				

\*DD = Developmental Disabilities    \*\*DD and SED waivers    \*\*\*1115 (a) Global Commitment Waiver

**Arizona, Hawaii, Vermont, Wraparound Milwaukee, and Choices** provide examples of states that have implemented strategies to maximize their ability to use Medicaid.

### **AZ** Arizona

#### **Using Tribal Behavioral Health Authorities**

Two of **Arizona's** 21 tribes opted to provide their own behavioral health services as Tribal Regional Behavioral Health Authorities (TRBHAs) through the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/BHS) managed care system. They saw the TRBHA as a means to maximize their ability to use Medicaid and integrate Tribal-run and county-based services under the TRBHA network. Health and behavioral health services provided by Indian-run facilities are eligible for 100% federal Medicaid contribution, known as the federal pass-through program. In effect, Arizona tribes deal with a bifurcated Medicaid system – the 1115 waiver in the state and the federal pass-through for tribes. The federal pass-through benefit is more traditional than the array of services covered under the 1115 waiver, but the federal rate is higher than state rates, and there is 100% federal funding. For example, case management is not a covered service by the pass-through, but it can be paid for through the 1115 waiver. The TRBHA can “pick and choose” whether to bill the federal pass-through or the 1115 waiver. The federal pass-through can only be used for services directly provided by the tribe.

**HI Hawaii*****Creating a Behavioral Health Carve-Out for Children and Adolescents and Partnering with the Schools***

The state has maximized the use of Medicaid to fund children's behavioral health services and supports. **Hawaii** has an 1115 Medicaid waiver. The managed care system ("Quest") is implemented by three health plans. With respect to mental health, these plans are responsible for all EPSDT services, outpatient mental health services, acute psychiatric hospitalization, and pharmacy services. The strategy used for Medicaid financing was to create a behavioral health carve-out for children and adolescents with serious emotional problems that is administered by the Child and Adolescent Mental Health Division (CAMHD). In 1994, a memorandum of understanding (MOU) with the state Medicaid agency created this carve-out, called the Support for the Emotional and Behavioral Development of Youth (SEBD) Program. Children from three to 20 years of age may be eligible to receive the services provided through the CAMHD system. Children and their families in the plan receive case management services and access to a comprehensive array of services and support. Medicaid pays CAMHD a negotiated case rate per member (i.e., child in service) per month. The case rate is negotiated based on demonstrated service utilization and setting "reasonable" rates for services. Reconciliation to cost is accomplished at the end of each year. Enrollment in the carve-out is limited to youth with serious disorders; eligibility for the SEBD Program is determined by the CAMHD medical director and is based on diagnosis and functional impairment. The array of services provided through the CAMHD system was added to the Medicaid state plan; some services are still pending approval. The SEBD Health Plan has resulted in benefits including increased accountability in the children's behavioral health system, greater focus on the rights of youth and families, and increased evaluation of the system.

In addition, the state Department of Education is a Medicaid provider and provides outpatient counseling (individual, group, and family) as well as assessments, medication management, and supports in schools. Providers may be employed by the school district or by contracted providers (both agencies and individual providers).

**VT Vermont**

***Implementing a Home and Community-Based Services Waiver***

One of the early steps taken by **Vermont** to cover children with serious emotional disturbances, including those not eligible for Medicaid, was to secure a home and community-based services (HCBS) waiver. In the early 1980s, Vermont sought the waiver to provide home and community alternatives for children in residential programs whose number had been growing substantially, in part due to the closing of the state psychiatric hospital. The waiver program, implemented in 1982, was the first HCBS waiver in the country for children with SED and allowed the state to: 1) cover additional children, some of whom were otherwise ineligible for Medicaid and 2) offer additional home and community services (e.g., respite care, crisis intervention, therapeutic foster-care, family supports, community/social supports, and environmental modifications) than the state could support prior to the waiver. In 1988, Vermont Act 264 was passed, giving the state a codified structure to expand and coordinate services in increasing state funding that could be used to fund services directly and to provide Medicaid match. Further expansion and investment to support home and community-based services occurred in 1991 when the state began covering children with serious emotional disturbance and other disabilities under the Katie Beckett option, and later under an expanded rehabilitation option that includes targeted case management. These strategies form the foundation of financing home and community-based services in Vermont’s system of care.

**AZ Arizona and Wisconsin Wraparound Milwaukee** **Wraparound Milwaukee**  
***Using Family of One***

“Family of One” allows States to waive parental income limits for a child who is expected to utilize an institutional level of care for 30 days or more.

- **Arizona** uses the “Family of One” strategy for inpatient and residential treatment services, in addition to other Medicaid options.
- **Wisconsin** uses this strategy for inpatient services only.

## **Choices** Choices

### ***Employing Care Coordinators in Medicaid Provider Agencies***

**Choices** uses several strategies to maximize the use of Medicaid to finance service delivery. In both **Indiana** and **Ohio**, the case rates do not necessarily finance all of the services included in the service coordination plan. For children who are Medicaid eligible (about 90% qualify for Medicaid), Medicaid is billed for allowable behavioral health services, such as individual and group therapy, day treatment, and inpatient hospitalization, as well as for case management and other services through the rehabilitation option, leaving the case rate funds to finance many of the supportive services that might not be covered by Medicaid.

In Indiana, care coordinators are hired by the mental health centers and are employees of those centers although they work with Dawn. In this way, Medicaid can be billed for care coordination services under the Rehabilitation Option, bringing \$1.7 million of Medicaid resources into the mix of resources supporting service delivery. Also in Indiana, Medicaid can be billed for individual, family, and group therapy; day treatment; and acute hospitalization for eligible youngsters, bringing in financing to support services above and beyond the case rate provided by the referring agencies.

In Ohio, Choices became a Medicaid provider, thereby allowing care coordination staff employed by Choices to receive Medicaid reimbursement under Ohio's Medicaid regulations. This brings approximately \$800-900,000 in resources into the system. The state Medicaid plan in Ohio includes a broad package of covered services. Choices bills Medicaid for services delivered that are covered under Medicaid. If Medicaid denies payment, or if services are not covered, Choices finances these services and supports from the case rate funds.

---

## ► Use Medicaid in Lieu of Other Funds (i.e., State General Revenue)

*Arizona, New Jersey, and Central Nebraska* offer examples of strategies for using Medicaid to finance services and support instead of state-only funds.

### **AZ** Arizona

#### ***Identifying Medicaid-Reimbursable Services and Expanding Authorization Criteria***

State Medicaid officials indicated that in planning for implementation of the JK settlement agreement, they went through a process of matching services provided by the juvenile justice system to Medicaid-codeable services. Also, the mental health and child welfare systems worked to identify utilization and costs associated with behavioral health services financed by the child welfare system that were being provided to Medicaid-eligible children and which could be covered by Medicaid instead of using all state general revenue dollars. Specifically, the two systems, working with Medicaid actuaries, determined what was being spent by child welfare on services to Medicaid-eligible children in licensed secure and non-secure residential treatment centers and acute inpatient hospital care. The analysis also showed that most of these children were in Maricopa County. Specific dollars were re-allocated to the contracted Medicaid behavioral health managed care organization in Maricopa County to begin funding these services through the behavioral health managed care system. Through their analysis of service utilization, the agencies also identified a number of child welfare-involved children whom they felt should be in Medicaid-financed therapeutic foster care or in Medicaid-financed counseling services. Additional funds were earmarked for the behavioral health managed care system for child welfare-involved children to support their involvement in these less restrictive services, including therapeutic foster care and outpatient programs.

### **NJ** New Jersey

#### ***Adding Services to State Medicaid Plan***

*New Jersey* identified services previously supported solely with state dollars that could be considered part of the state Medicaid plan. The state then covered these services under Medicaid through the Rehabilitative Services Option. This allowed the state to secure federal funding for services that it had provided to children before 2001 for which it had not claimed federal match. New Jersey used these “freed” state dollars as seed money to build the infrastructure for new community services across the state. In the first year of its system of care reform, New Jersey financed its share of Medicaid costs by combining \$167 million in existing state dollars for children with serious emotional disorders from the child welfare and mental health divisions (including \$117 million which was previously expended by the Department of Youth and Family Services [DYFS] on residential care) with \$39 million in new funds authorized for children with serious emotional disorders in the Governor’s 2001 budget.

**NE Central Nebraska**

***Redefining Services to be Medicaid Reimbursable***

The state child welfare system had paid the cost of care for youth placed in a “Group Home 2.” These homes actually were serving youth with significant treatment needs and offered 24-hour awake supervision, maintained a high staff-to-child ratio, and offered specific treatment techniques. The state believed that this was a mental health service rather than a placement service, renamed it as “enhanced group home” care, built it as a medical model, and began using Medicaid, rather than child welfare, funds to reimburse for the treatment services.

**► Generate Medicaid Match**

Both *Vermont* and *Wraparound Milwaukee* demonstrate how funds from other programs and systems can be used to provide Medicaid match.

**VT Vermont**

***Using Funds from Other Programs and Systems for Match***

The state uses funding contributed by other child-serving systems and mental health general revenue to provide the Medicaid match. *Vermont’s* success in identifying and securing funds for Medicaid match from other systems is a significant factor in being able to maintain and expand services. For example, the autism spectrum program operated by the Howard Center (the Designated Agency in Chittenden County) has expanded since its beginnings in 2000 to now provide a continuum of specialized, comprehensive educational and behavioral support and treatment services to children, youth, and young adults ages 2–21. The program is directly funded by school districts, whose payments to the Howard Center serve as match for the billing of Medicaid for treatment-related services. This funding mechanism supports Vermont’s vision of partnership between local schools and community mental health centers to meet the needs of children with mental health and developmental disabilities. Medicaid has become a greater proportion of all revenues as children’s mental health services have expanded. State agency partners also expanded in number and participation in the system of care; and support from their general fund allotments has provided a source to draw down federal Medicaid funds to pay for services.



**Wraparound Milwaukee** **Wraparound Milwaukee**

***Using Funds from Other Systems for Match***

Use of Milwaukee Public Schools and child welfare general revenue for mobile crisis services helps to generate Medicaid match for this service. **Wraparound Milwaukee** operates the County’s mobile crisis program for county youth (Mobile Urgent Treatment Team [MUTT]), which is supported by multiple funding streams. Every child enrolled in Wraparound Milwaukee automatically is eligible for services from MUTT, and other families in the county may use it for a crisis related to a child. The child welfare system and Milwaukee Public Schools wanted an enhanced, dedicated mobile crisis team to provide crisis intervention and on-going (30-day) follow-up. Each provides funding of \$450,000 to support this enhanced capacity. Wraparound Milwaukee also is able to bill Medicaid for this service under Wisconsin’s crisis benefit. This includes the MUTT crisis team; a portion of care managers’ time spent preventing or ameliorating crises; 60% of the cost of crisis placement in a group home, foster home or residential treatment facility; and the cost of 1:1 crisis stabilizers in the home. Since Wraparound can recover a percentage of its costs by billing Medicaid, it is able to add about \$180,000 to the Milwaukee Public Schools enhanced capacity and about \$200,000 to the child welfare capacity. Wraparound’s total Medicaid crisis reimbursement was nearly \$6 million in 2006.

▶ **Maximize Education/Special Education Funds**

An example of maximizing special education funds is provided by Choices, where the education system pays a case rate to obtain services to avert the need for an out-of-school or residential placement.

**Choices** **Choices**

***Receiving Case Rates from the Education System***

Of children served in Indiana by **Choices** (Dawn), 70% are in special education. When children are referred by the education system, their case rate is paid by the education system. Some of these children are in the “at risk” tier of services (with a case rate at \$1,809 per month), with the goal of averting the need for an out-of-school or residential placement.

## C. Redirect Spending from “Deep-End” Placements

### **Strategies include:**

- Redirecting dollars from deep-end placements to home and community-based services and supports
- Investing funds to build home and community-based service capacity
- Promoting the diversification of residential treatment providers to provide home and community-based services

### ► **Redirect Dollars from Deep-End Placements to Home and Community-Based Services and Supports and Monitor Effects on Service Utilization**

All of the sites have implemented strategies to redirect resources from deep-end placements to home and community-based services and supports. This is an absolutely critical financing strategy as there are seldom new dollars for children’s services; expansion of home and community-based capacity must depend on redirected resources to a great extent.

#### **AZ** **Arizona**

#### ***Using 1115 Waiver to Develop Home and Community-Based Services***

The entire thrust of the 1115 Medicaid waiver is to develop home and community-based alternatives to out-of-home services. The **Arizona** behavioral health system, working in partnership with the state Medicaid agency, significantly expanded the array of covered services and supports by adding new service types to the Medicaid benefit and expanding service definitions of already covered services. In addition, rates were restructured to better correspond to system goals of encouraging the provision of home and community-based services and reduced reliance on residential treatment. Rates for residential treatment, for example, decline as lengths of stay increase. The state reported that in 2003, 39% of the child behavioral health budget went to 3.6% of enrolled children served in residential treatment centers (RTC) and inpatient hospitals. In 2005, this had been reduced to 29%–16.25% on inpatient hospitalization and 13.4% on other out-of-home (residential Levels I, II, III, including therapeutic foster care). Currently, 2.6% of the 33,000 youth served statewide (about 850 youth) are served in out-of-home treatment settings, but 40% of those placements are in family-based therapeutic foster care (TFC), rather than congregate settings. In 2003, the system had nine TFC placements statewide, compared to about 400 today. Value Options (VO) in Maricopa reported that it spent \$25–30 million of its budget (about 25%) on out-of-home services and \$70–90 million (about 75%) on home and community-based services. At the same time, child welfare in Maricopa reported that it is spending less on RTC because of successful appeals to get VO to pay for the service.

---

VO indicated that “while we never used to talk to judges, court appointed special advocates, or guardians ad litem,” they have begun trying to educate these stakeholders about alternatives to RTCs. In addition, Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/ BHS) developed Practice Improvement Protocols related to use of RTCs, including one on Use of Out-of-Home Care Services and one on Therapeutic Foster Care. (See: <http://www.azdhs.gov/bhs/guidance/guidance.htm>.)

## **HI** Hawaii

### ***Using Training and Individualized Service Approach to Shift Practice and Resources***

**Hawaii** has sought to redirect dollars from deep-end placements to home and community-based services and supports as the service array has been expanded. Access to deep-end services has not been restricted, and there are no specific line items in the budget for residential vs. nonresidential services. Rather, education/training and technical assistance have been used in an attempt to shift practice to a home and community-based approach. As community-based service capacity has expanded, utilization of residential services has been reduced. The approach taken by the state has relied upon training and encouragement to shift to a home and community-based service philosophy. Child and family teams, however, are empowered to authorize whatever services they deem necessary, and the Child and Adolescent Mental Health Division (CAMHD) is obligated to pay for the services they authorize for a child and family.

The state has had a focused initiative on bringing children back from out-of-state placements. The initiative represents a collaboration among the mental health system (Department of Health), education system, and the court system. In 1999, there were 89 children out of state. Individualized service plans were developed child by child to bring these children back. Currently, there are only 6 children in out-of-state placements. In order to send a child to the mainland for treatment, all three departments (Departments of Health, Education, and Human Services) must sign off; this requirement alone creates a disincentive to out-of-state placements.

CAMHD in the Department of Health bears the cost of out-of-state placements. The state has found that it is not necessarily less costly to develop and implement a wraparound plan and to keep a child in the community as compared with an out-of-state placement. This approach, however, is considered to be better practice. Attempts are made to bring children back from out-of-state placements to therapeutic foster care rather than residential treatment centers. Dollars in the budget are not held to line items, so that dollars can follow the child. Thus, dollars can be moved from mental health residential care to community-based services as the locus of treatment shifts.

A Resource Management Section of CAMHD’s Clinical Services Office tracks matches between children’s needs and system resources to facilitate development activities that focus on ensuring sufficient capacity and efficient use of available resources. Patterns and trends in service delivery are examined that identify and discourage the prolonged use of ineffectual services, overly restrictive services, or non-evidence-based interventions. Regular reviews are conducted to examine documented needs and the intensity of services provided. When problems are identified, this section provides the data necessary for CAMHD to take action to align services with CAMHD’s practice guidelines and policy.

**NJ New Jersey*****Implementing a Statewide System of Care Reform with Care Management Organizations for Youth with Complex, Multi-System Issues***

**New Jersey** has committed to move dollars from deep-end placements to community-based services by creating entities such as a Contracted Systems Administrator (CSA), Care Management Organizations (CMOs), and Family Support Organizations (FSO's). Though the state has struggled in this area and a lot of monies are still used for residential services, the amount has been steadily declining over time. There is one CMO and FSO per region; they are slated to work together to provide care coordination and create individualized plans for children with complicated and intensive needs. The FSOs employ Family Support Coordinators and Community Resource Development Specialists, who are responsible for identifying and formulating natural helpers and informal community supports to enhance treatment services.

Spending on residential care has increased in recent years because New Jersey has provided services to more children, expanded the capacity of the residential system to meet the need, and raised the reimbursement it pays to facilities. However, growth in spending for community services has dramatically outpaced growth in spending for residential care, meaning that residential care now constitutes a smaller fraction of the overall budget for children's mental health than it did before New Jersey implemented its system of care reform — 60% instead of 90%. State officials, however, believe that the amount spent on residential care, while a significant improvement, remains significantly too high.

Data are also available on cost per child served on a county basis. In fiscal year 2000, New Jersey spent the bulk of its children's mental health service expenditures, 72%, on inpatient and residential care. The percent of total expenditures utilized for residential and inpatient services ranged from 48% (a significant outlier) to 85%. This picture has changed considerably in all counties. In 2005, the statewide average was 39% spent on inpatient and residential care. Ocean County had the lowest rate, 20%, and Warren County the highest at 56%.

A further examination of 2005 data stratified by county reveals how system of care implementation, still underway in New Jersey, affects the use of out-of-home care. There appears to be little difference in the way that system of care has affected the number of children using inpatient services. Both Phase 1, the original system of care implementers, and Phase 3 counties use inpatient services at a similar rate, with Phase 2 showing a smaller range in rates for its smaller number of counties. But the use of residential care appears to have shifted considerably with the implementation of systems of care. Phase 1 and Phase 2 counties use residential for fewer children than do Phase 3 counties who had not yet implemented systems of care.

**VT Vermont*****Implementing Gate-Keeping Process and Developing Home and Community-Based Capacity***

The state's vision and goal seeks to build home and community-based services capacity resulting in a low use of residential services. Savings from reduced utilization of residential treatment services are captured and redirected to community-based services. While there are specialized residential services and a hospital for statewide access, the system of care vision, state law and practice have worked to establish home and community-based capacity and expand services, utilizing dollars that would have otherwise been allocated to more costly options (i.e., redirection), as well as using new funds for community services.

In the early 1980s, few types of mental health services were available in Vermont; typically there was a 50-minute therapy session or psychiatric in-patient care for a few weeks. The system of care concept encouraged the state to develop an array of services to meet needs in the home, school, and community, most notably case management, respite, and short-term hospital diversion beds. The number of children ages 0–12 and 13–19 who received children's services through community mental health centers tripled from 1989 through 2005, from about 3,200 to 10,000. This is a high penetration rate, about 8%, compared to most states, and very few of the children served are in hospital-level care.

**Vermont** used its Medicaid Home and Community-Based Services waiver as one financing component in building the system of care and supporting effective services to more children with serious disturbances in their communities rather than in inpatient settings. Evaluation of the Vermont waiver program found that the cost per child under the waiver was about \$150 per day compared to \$1,200 per day for inpatient services.

Training has also been provided over several years to staff on how to wrap intensive services around children with high needs and their families, thus helping to avoid unnecessary disruption to a child's family life and school/social environment.

In addition to expanding home and community based service capacity, the state also created a gate-keeping mechanism for intensive, restrictive services. Vermont's Case Review Committee (CRC) was established by the State Interagency Team to provide assistance to local teams as they identify, access and/or develop less restrictive resources, or when less restrictive alternatives are not appropriate, to ensure the best possible match between child and residential treatment facility. The CRC reviews all requests for intensive residential placement and intensive wraparound services that provide overnight staff 24 hours a day, seven days a week for children or adolescents with severe emotional disturbance. While the representatives from the departments review the proposed services together, funding decisions are made on a child-specific basis. CRC and/or agency staff may also provide technical assistance to ensure the child's return to home and community as quickly as possible.

**NE Central Nebraska**

***Developing a System of Care for Children in State Custody***

The Cooperative Agreement between the **Nebraska** Department of Health and Human Services (DHHS) and Region 3 Behavioral Health Services (BHS) to create an individualized system of care for children in state custody who have extensive behavioral health needs identifies reinvestment of cost savings to allow for more preventative, front-end, community-based services as one of its core principles. The agreement stipulates that if Region 3 BHS experiences costs less than the agreement amount, an expected outcome of the program, the cost savings may be used to: develop a risk pool (no more than 10%), serve additional youth in the target population or expand services to youth at risk of becoming part of the target population, and provide technical assistance to other Regions/ Service Areas to implement similar programming statewide.

In its 2005 Annual Report, Region 3 BHS demonstrates that the Integrated Care Coordination Unit has reduced out-of-home placements and increased the percentage of children who live in the community:

- At enrollment, 35.8% of the children (n= 341) were living in group or residential care; at disenrollment 5.4% of the children were in group or residential care
- At enrollment 2.3% were living in psychiatric hospitals; at disenrollment no children were hospitalized
- At enrollment 7% were living in juvenile detention or correctional facilities; at disenrollment no children were in these facilities
- At enrollment 41.4% were living in the community (at home – 4.4%, with a relative — 1.5%, or in foster care — 35.5%); at disenrollment, 87.1% lived in the community (at home — 53.5%, with a relative — 7.6%, in foster care — 14.5%, independent living — 11.5%).

Other outcome measures show that CAFAS scores dropped significantly (i.e., improved) for children enrolled in the Professional Partners Program, Integrated Care Coordination Unit, or Early Intensive Care Coordination, and their living situations improved.

**Choices Choices**

***Using Redirection to Home and Community-Based Care as Basis for Service Delivery***

The philosophy of **Choices**, and how its services are marketed, is the concept of redirecting care from deep-end placements to home and community-based services. This forms the basis for the entire concept of service delivery.



**Wraparound Milwaukee** **Wraparound Milwaukee**  
***Using Redirection to Home and Community-Based Care as Basis for Service Delivery***

**Wraparound Milwaukee** has achieved significant reductions in use of deep-end placements, namely in use of inpatient hospitalization, residential treatment, and juvenile corrections facilities.

Prior to Wraparound Milwaukee, Milwaukee County’s Child and Adolescent Services Branch operated a 120-bed inpatient unit with an average length of stay (ALOS) of 70 days. Over about a 15 year period, as Wraparound Milwaukee developed, the Branch closed beds. The state Medicaid agency provided “bridge” money to close inpatient beds by giving the Branch 40% of the DRG (Diagnosis Related Group) rate for every child diverted from inpatient care. These dollars helped to build home and community-based service capacity. Today, the ALOS is 1.7 days, and inpatient utilization has declined from 5,000 days a year to 200.

In Milwaukee County, the child welfare and juvenile justice systems pay for residential treatment centers (RTC); RTC level of care is not paid for by Medicaid, mental health or education systems. Wraparound Milwaukee has reduced the use of residential treatment centers (RTCs) from an average daily population of 375 to 50 youth. The ALOS is 90–100 days. Wraparound Milwaukee estimates that if the child welfare system had not invested in Wraparound Milwaukee, the \$18 million that child welfare was spending ten years ago on residential treatment would be \$46 million today. Instead, Wraparound Milwaukee essentially is using the same monies that were in the system ten years ago, without new state or county revenues, to serve more children in home and community services with better outcomes. Even with the results it has achieved, Wraparound Milwaukee stakeholders note that out-of-home placements are expensive, and the costs of out-of-home care have been rising. Sixty percent of Wraparound Milwaukee’s budget goes to residential treatment, group home, therapeutic and regular foster care. The average per-child-per-month cost of care is \$3,500, whereas the average cost for a child using only home and community services and supports is \$1,700. (Note. These costs must be considered within the context of Wraparound Milwaukee’s very “high-end” target population, which is those youth with the most serious behavioral health challenges, who also are involved in multiple systems. These are not costs spread across all children in the county. They also need to be considered in the context of the costs of residential treatment, which run about \$7,000 per member per month (pmpm), inpatient hospitalization, which run about \$18,000 pmpm, and correctional placements, which run about \$6,000 pmpm.)

The county juvenile justice system pays for the cost of placements for youth in state corrections facilities. By diverting youth to Wraparound Milwaukee, the county juvenile justice system can save dollars and get better outcomes. Wraparound Milwaukee’s average monthly costs for youth referred by juvenile justice are about \$3,500 pmpm, compared to \$6,000 pmpm for juvenile detention. Wraparound Milwaukee also has reduced recidivism rates for youth in juvenile justice by 60% from one year prior to enrollment to one year post enrollment. Looking at subsets of the juvenile justice population, Wraparound Milwaukee achieved a 34% decrease in the average per child per month cost of residential care for youth with sex offenses. (This was in spite of a 15% increase in residential fees during the same period.) Use of group homes dropped 75%. In place of congregate care, Wraparound Milwaukee provides crisis one-to-one stabilization, parent assistance, therapeutic foster care, offense-specific doctoral-level individual therapy, in-home therapy, parent education and support, safety plans, and a range of other individualized services to this population.



In addition to use of the wraparound approach to reduce use of deep-end services, Wraparound Milwaukee also operates a mobile crisis team — Mobile Urgent Treatment Team (MUTT) — paid for by a Medicaid crisis benefit (separate from the Medicaid capitation Wraparound Milwaukee receives). The county provides 40% of the match and receives 60% of federal reimbursement from the state. Milwaukee’s mobile crisis capacity can be utilized very flexibly, including providing access to psychiatrist, psychologist, and paraprofessional services (using different billing codes). The team itself is comprised of three licensed psychologists and five clinical social workers and is available 24 hours a day. The crisis benefit is utilized for mobile crisis stabilization by the crisis team, as well as by Wraparound Milwaukee care coordinators, who can use the benefit for time spent on crisis planning and crisis stabilization activities. Time spent by crisis team members or by care coordinators on activities related to preventing crises, ameliorating crises, or linking youth and families to crisis services is covered under the crisis benefit. The benefit also can be used to cover crisis group homes and crisis foster homes, up to \$88/day in non-room and board costs. Milwaukee has found that the crisis benefit is a key factor in reducing use of deep-end services. Wraparound Milwaukee has a separate \$450,000 contract with the child welfare system for use of MUTT, which it has found is helping to prevent placement disruption of children in child welfare; this funding from child welfare enabled MUTT to add staff, who also can bill Medicaid. The placement disruption rate in child welfare has been reduced from 65% to 38%. Recently, Milwaukee Public Schools contracted with Wraparound Milwaukee (a \$450,000 contract) to utilize MUTT in the schools.

## ► Invest Funds to Build Home and Community-Based Service Capacity

*Arizona, Hawaii, New Jersey, Vermont, Central Nebraska,* and *Wraparound Milwaukee* have invested funds to develop home and community-based service capacity.

### **AZ** Arizona

#### ***Increasing Funds Spent on Home and Community-Based Services***

Through the managed care system and as a result of the JK lawsuit, there has been an increase in dollars spent on home and community-based services. The behavioral health system, working in partnership with the state Medicaid agency, significantly expanded the array of Medicaid-covered services, both by adding new service types and expanding service definitions of already covered services. Rates were restructured to encourage provision of home and community-based services. A new type of Medicaid provider was created — community service agencies — specifically to broaden the availability of home and community based services. In addition, **Arizona** Department of Health Services, Division of Behavioral Health Services (ADHS/BHS) includes non-Medicaid dollars, including state general revenue and block grant funds, in the capitation that Regional Behavioral Health Authorities (RBHAs) receive, which can be used for expanding the availability of home and community-based services. Any “savings” generated through managed care are re-invested, and there is a legislative prohibition against using savings generated by children’s programs for adult services. Value Options (VO) in Maricopa County has used savings to expand the availability of therapeutic foster care.

## **HI** Hawaii and **NJ** New Jersey

### ***Investing in Service Capacity Development with State Funds***

- In **Hawaii**, capacity building and start-up funds come from the existing Child and Adolescent Mental Health Division (CAMHD) budget. CAMHD resources have been used to build capacity to provide services such as Multisystemic Therapy (MST), and Multi-Dimensional Treatment Foster Care.
- In **New Jersey**, the state changed its Medicaid plan to include reimbursement for more comprehensive services and to create new service capacity. State dollars were also used to fuel this initiative by investing in service capacity development. Some of the community-based services that were added include: care management, mobile crisis services, wraparound, family care homes and family support services.

## **VT** Vermont

### ***Using Multiple Funding Sources for Service Capacity Development***

**Vermont's** system of care history illustrates capacity building financed by federal Medicaid and grant dollars, state general revenues and private resources. The state's Home and Community-Based Services Medicaid waiver and CASSP funding in the 1980s, along with state dollars and a grant from the Robert Wood Johnson Foundation, spurred the creation of interagency networks and services leading to the establishment of the system of care. Federal Medicaid and grant funding, along with state statutes and policies, foster and fund continuing growth in behavioral health services for children. Medicaid is the principal payer for most services and the state's high levels of Medicaid and S-CHIP eligibility and broad package of coverage have contributed significantly to service expansion. Funding for new services comes from a variety of sources. For example, the Children's Upstream Services project (CUPS), funded by a federal system of care grant, seeded Vermont's community-based mental health services for young children experiencing emotional disturbance. The initiative focused attention on very young children, the kinds of services they and their families needed, and the resources and networks required. The initial CUPS financing model supported only "pull-out" services (i.e., services that call for removing a child from a setting for treatment/intervention with subsequent reintegration back into the initial setting). However, interagency teams of parents and providers engaged in the process identified a primary need for early education and consultation services to public and private child care and service providers to increase their skill level in working with young children with mental health issues and their families and in developing more supportive environments for them. This reduced the need for removal of the child and increased the knowledge and skills of community providers about the development of all children. The latter involved conversations with the state's higher education community and, ultimately, led to expanded curricula, certification, and degree options. Based on positive outcomes of the CUPS initiative, mental health, other agencies, and family representatives at state and local levels partnered successfully to secure funds (federal grant, state general revenue) to develop service capacities in these areas so that children would not have to be removed from pre-school classrooms, child care programs and the like.

**NE Central Nebraska**

***Using Savings to Invest in Service Capacity Development***

In addition to improved outcomes, the Integrated Care Coordination program (ICCU) has also achieved a cost savings. With this savings, **Central Nebraska** has been able to implement the principle of reinvestment and expand services for youth at risk of becoming part of the target population. In 2001, ICCU produced a cost savings of \$500,000 (this later grew to \$900,000). There was discussion of returning these funds to the state to help with a significant budget deficit facing child welfare. Instead, the director of the Department of Health and Human Services supported the alternatives that were laid out in the cooperative agreement. Central Nebraska kept the cost savings and used it both to provide technical assistance to other regions/service areas to implement similar programming and to expand the population of children and families served.

A portion of the ICCU cost savings was used to create the Early Intensive Care Coordination Program (EICC), which seeks to prevent children who have entered the child welfare system from being removed from their homes and from remaining in the system. If they are removed, EICC works to expedite their return home by using the wraparound approach and family-centered services. EICC served 67 youth and their families in fiscal year 2005. They prevented placement in state custody for 88.1% of these youth. (Note: Currently, Central Nebraska is unable to continue its EICC Program due to state policy changes limiting the use of these funds to children who are currently in state custody. As a result, the local system of care identified other service gaps for children already in custody who are served by ICCU. The funds are now being used to provide a School-Based Intervention Program for these youth.)

**Wraparound Milwaukee Wraparound Milwaukee**

***Using Savings to Invest in Service Capacity Development***

All of the savings generated by **Wraparound Milwaukee** are reinvested in the system to serve more youth or build more service capacity. Wraparound Milwaukee has over 200 providers (agencies and individuals) in its network, representing 85 different services and supports and including over 40 racially and culturally diverse providers. The approach it takes to building capacity is to build “target population by target population.” At the time of the site visit, additional service capacity issues were identified for girls and for youngsters with co-occurring emotional disturbance and developmental disabilities and youngsters with autism, who are at risk for residential placement and whose families are involved with child welfare. These children often end up in Wraparound Milwaukee, constituting about 10% of the Wraparound population. Wraparound Milwaukee’s approach is to develop customized service network responses to population issues as they arise.

---

## ► Promote Diversification of Residential Treatment Providers to Home and Community-Based Services

Most of the states and communities studied have worked with residential treatment providers to encourage them to adopt the system of care philosophy and approach, to work in partnership with local systems of care, and to diversify by providing new types of services and supports.

### **AZ** Arizona

#### ***Collaborating with Residential Treatment Providers to Diversify***

**Arizona** is undertaking a number of strategies, including putting a workgroup together to look at service gaps and what the research says for particular subsets of youth, such as those with sexual offenses, who often are sent to out-of-state residential treatment centers (RTCs). The state is then looking at getting the in-state RTC providers to the table to look at service development issues. Therapeutic foster care will continue to play a bigger role, with the state looking at possibly increasing rates for therapeutic foster care and developing or implementing a training curriculum for therapeutic foster homes. The curriculum would be built on the curriculum for child welfare foster homes, which emphasizes the role of active support for family reunification.

Value Options (VO) in Maricopa County reported that it is rewriting scopes of work for residential providers and Comprehensive Services Providers (CSPs) in their network to put responsibility on the RTCs and CSPs for continuing child and family teams while youngsters are in residential facilities, and VO is putting language in RTC contracts that these providers must work with the family of origin. VO also reported that they are talking to the state's child welfare system about training RTCs and others in use of "Family Finding" (e.g., using Internet search engines to locate extended family of youth in foster care in RTCs). VO also is trying to change its own case management from one of prior authorization/utilization management to one of coaching and facilitating skill sets to get RTCs and others more involved in the child and family team approach. VO also launched an "under 12" initiative to keep youngsters under the age of 12 out of RTCs and has talked to the RTCs about diversifying to provide more home and community-based care. Reportedly, VO has reduced the number of children under age 12 in RTCs, some RTCs have diversified, and two RTCs serving younger children closed. VO also is consciously trying to move youngsters to lower levels of care and is considering re-directing any "savings" to further developing community-based supports, rather than simply renewing RTC contracts. Most of the RTCs in the state are located in Maricopa County.

Providers indicated that most of the RTCs are diversifying their services (reportedly, all but one in Maricopa), and apparently beds are closing (one 80-bed facility in Maricopa, for example). One example given was that of Touchstone, an RTC provider in Maricopa that is now providing Multisystemic Therapy (MST), Functional Family Therapy (FFT), and therapeutic foster care.

## **HI** Hawaii and **Vt** Vermont

### ***Working with Residential Providers to Adopt System of Care Approach and Diversify***

RTCs developed a broader service array as part of the system of care:

- In **Hawaii**, residential treatment centers are contract provider agencies to the children’s mental health system. Some have diversified and now provide a broader service array, including such services as intensive in-home services and therapeutic foster care.
- In **Vermont**, residential treatment centers/programs have diversified and incorporated the system of care vision. For example, the child mental health program at Howard Center, the lead community mental health provider in Chittenden County, formerly served as a major residential treatment facility in the state. It now offers an array of programs and services from an integrated pre-school program (for pre-schoolers with and without mental health issues) to a day school to a residential program.

## **Choices** Choices

### ***Working with Residential Providers to Adopt System of Care Approach and Develop New Types of Services***

**Choices** has worked with residential providers, particularly in **Indiana**, to develop new types of services within the overall system of care. These include residential services which are based on system of care values and principles such that children are significantly more involved in their homes and communities and families are full partners in the service delivery process. A unique addition to the continuum of care provided through the Dawn Project is the Family Community Program at the Lutherwood Residential Treatment Center. Operated in partnership with Dawn, the program offers a nontraditional, strength-based residential program in which youngsters are integrated in the community as much as possible, family reunification is the goal, and parents are highly involved in treatment and decision making as members of the treatment team. Innovations include: families are engaged in new ways in the intake process; youth and families co-design the goals and interventions; youth are able to go home at night; no level systems are required before getting the “right” to go home; the strengths and culture of child and family are tied to the solutions; families are consulted for solutions to problem behaviors; a mobile support team for intensive family preservation is provided; families can be on the unit at any time; medications are left in charge of the family and community physician with consultation by the facility psychiatrist; an educational liaison is provided; and many youth remain in their home schools.

**Wraparound Milwaukee** **Wraparound Milwaukee**

***Using Market Forces to Create Changes in Residential Treatment Centers***

In effect, **Wraparound Milwaukee** let the market dictate the future of residential treatment centers (RTCs). Milwaukee made it clear it was going to utilize RTCs differently and was in the market for a broad range of services and supports. Virtually all of the RTCs in Milwaukee diversified in response to what Milwaukee Wraparound indicated it was willing to purchase, including contracting to provide care coordination. While few RTCs actually closed, beds were reduced, in some cases, campus facilities were sold or leased, and new home and community-based products were developed.

**D. Support a Locus of Accountability for Service, Cost and Care Management for Children with Intensive Needs**

***Strategies include:***

- Financing care management entities as a locus of accountability
- Incorporating risk-based financing strategies for high-need populations

**► Finance Care Management Entities as Locus of Accountability**

Many of the sites finance some type of entity as a locus of accountability and management for children with serious and complex challenges, who are involved in or at risk for involvement in multiple systems. These may be either a government entity or a private, nonprofit entity. Government entities are found in Hawaii, where the state children’s mental health agency administers the Support for the Emotional and Behavioral Development of Youth or SEBD Program through a carve-out under the state Medicaid program and utilizes seven public mental health agencies located throughout the state to coordinate service delivery. The regional government behavioral health and child welfare authorities are the locus of accountability in **Central Nebraska** through their use of a Care Management team and creation of Integrated Care Coordination Units, and a local government agency is the locus of accountability for **Wraparound Milwaukee**. Private nonprofit entities are found in **New Jersey**, which contracts with nonprofit Care Management Organizations in each region of the state. Vermont contracts with 10 local nonprofit lead agencies to fulfill similar functions, and **Choices** is a private nonprofit corporation that is contracted by government agencies to serve as a care management entity and locus of accountability.



## **HI** Hawaii

### ***Using a State Government Agency***

**Hawaii's** children's mental health system is administered by the state government, specifically the Child and Adolescent Mental Health Division (CAMHD) of the Hawaii Department of Health (DOH). Over the past five years, CAMHD's system of care shifted from a comprehensive mental health service system for all children and youth to a system focused on providing more intensive mental health services to the population of youth with more serious and complex behavioral health disorders and their families. Through a memorandum of understanding (MOU) with the state Medicaid agency, CAMHD operates a carve-out under the state Medicaid program that serves youth with serious emotional and behavioral disorders (the Support for the Emotional and Behavioral Development of Youth or SEBD Program). CAMHD receives a case rate from Medicaid for each child in service and provides a comprehensive array of services and supports. Operation as the prepaid health plan for Medicaid eligible youth began in 2002. The functions under the purview of the state office include governance of the system, performance management, business and operational management, research and evaluation, and training and practice development/improvement. Under the CAMHD structure are seven public Family Guidance Centers (community mental health centers), located throughout the state, which are responsible for mental health service delivery to children and adolescents and their families. CAMHD also contracts with a range of private organizations to provide a full array of mental health services. Public employees within the Family Guidance Centers provide care coordination services, assessment and outpatient services, and arrange for additional services with contracted provider agencies.

## **NJ** New Jersey

### ***Using Nonprofit Care Management Organizations***

**New Jersey's** system of care initiative created Care Management Organizations (CMOs), which are nonprofit entities at the local level (one per region) that provide individualized service planning and care coordination for children with intensive service needs under contract with the state. Currently, contracts are non risk-based. CMOs use child and family teams to develop individualized plans, which are required to be strengths-based and culturally relevant. They also must address safety and permanency issues for those children referred to CMOs who are involved with the child welfare and juvenile justice systems. The CMOs employ care managers, who carry small caseloads (1:10) and who receive close supervision and support from clinical supervisors. Care managers and child and family teams are supported by family support coordinators and community resource development specialists, whose job it is to identify and develop informal community supports and natural helpers to augment treatment services. The Care Management Organizations work closely with Family Support Organizations (i.e., family-run organizations) to link families to natural supports and a peer network.



## **VT** Vermont

### ***Using Local Lead Agencies and Interagency Teams***

**Vermont's** system of care for children with behavioral health problems has state and local structures that serve as focal points at each level and across systems for policy and management. The Department of Mental Health is the lead state office for children's mental health. The Department's Child, Adolescent and Family Unit contracts with ten local Designated Agencies (nonprofit, designated by the Commissioner) that serve the state's 14 counties to provide community mental health services for a specific geographic region. The Designated Agency is the locus of accountability for services, cost, and care management for children with intensive mental health needs. The local agency that has lead responsibility for ensuring that the coordinated service plan (developed by an individual interagency treatment team) is in place can vary depending on the needs of the child and family. If the child is in the custody of the Department for Children and Families (child welfare agency), then that agency takes the lead. If the issues are primarily exhibited in the child's educational environment and the child is not in state custody, then the local school district is responsible. In all other cases, the designated community mental health agency is responsible for developing and making sure that the coordinated services plan that outlines goals and needed services and supports is carried out. Decisions about services, care and cost are made at the local level, driven by the needs of the child and family and provided within the limits of legislative mandates and existing resources. If problems or issues arise that the individual treatment team cannot resolve, the team or any member may initiate a referral to the Local Interagency Team in the region for help. The State Interagency Team is a mandated state-level unit for further consideration of issues that are not resolved locally and for additional assistance with implementation of the coordinated service plan.

## **NE** Central Nebraska

### ***Using Integrated Care Coordination Units Supported by Regional Behavioral Health and Child Welfare Authorities***

Region 3 based its system of care on an existing infrastructure (Region 3 Behavioral Health Services [BHS]). When it received a federal system of care grant in 1997, there was no need to create and support a new structure to implement the system of care. Region 3 BHS already had a statutory responsibility to administer behavioral health services. Using the existing infrastructure rather than creating a new, separate entity with grant funds greatly enhanced the chances for sustainability. The cooperative agreement between the **Nebraska** Department of Health and Human Services (DHHS) and Region 3 BHS to establish an individualized system of care for youth with intensive needs who are in state custody included a joint responsibility for utilization management to monitor utilization of higher levels of care and assist care coordinators in accessing alternative placement and treatment services. The Care Management Team (CMT) serves this function. It was developed to ensure that children/youth are cared for in the least restrictive, highest quality, and most appropriate level of care. It serves children at risk of out-of-home placement, as well as children in out-of-home placement. To determine the most appropriate level of care, the CMT administers an initial assessment using the Child and Adolescent Functional Assessment Scale (CAFAS), interviews caregivers, reviews youth

records (including mental health assessments and risk assessment) and participates in the child and family team meetings when necessary. The CMT tracks referrals from DHHS and other service providers, determines needed services and supports, and identifies service gaps. The CMT determines which children/families in Central Nebraska meet the criteria for the Intensive Care Coordination Unit (ICCU), which ICCU has the capacity to accept them, and which children should be prioritized to receive care first. If there is no opening in an ICCU, the CMT will facilitate a child and family team meeting. The CMT conducts ongoing utilization review of children in ICCU. The CMT is staffed by licensed mental health clinicians. This is very helpful in the negotiations with Magellan, the statewide Administrative Services Organization, for access to Medicaid services for individual children. Region 3 BHS and the Central Area Office of Protection and Safety fund the CMT. In FY 2005, 210 youth were referred to the CMT.

**Choices Choices**

***Using a Private, Nonprofit Corporation***

**Choices** is the care management entity that serves as the locus of accountability for youth with intensive service needs. The county (Marion County, **Indiana** and Hamilton County, **Ohio**) or state (for Montgomery County and Baltimore City, **Maryland**) contracts with Choices to assume this role. Choices is a private nonprofit corporation that was created by four Marion County community mental health centers as a separate and independent entity to manage the Dawn system of care. Fulfilling the role of a “care management organization,” Choices provides the necessary administrative, financial, clinical, and technical support structure to support service delivery and manages the contracts with the provider network that serves youth and their families. The responsibilities of Choices include providing financial and clinical structure; providing training; organizing and maintaining a comprehensive provider network (including private providers); providing system accountability to the interagency consortium; managing community resources; creating community collaboration and partnerships; and collecting data on service utilization, outcomes, and costs.

**Wraparound Milwaukee Wraparound Milwaukee**

***Using a Local Government Agency***

**Wraparound Milwaukee’s** primary function is to serve as a designated locus of accountability for children and youth with intensive needs and their families, specifically those with serious behavioral health challenges who are at risk for inpatient, residential treatment or correctional placement. At the administrative level, the locus of accountability is through the Child and Adolescent Services Branch of the Milwaukee County Behavioral Health Agency, which serves as a “Management Services Organization,” similar to an Administrative Services Organization in managed care. The Branch utilizes the tools of managed care to manage utilization and quality and is at financial risk through the Medicaid capitation it receives, as well as through case rates from child welfare and juvenile justice. At the service delivery level, care coordinators with case ratios of no more than 1:8 serve as the locus of accountability for individual children and their families. Also, individualized child and family teams are accountable for ensuring appropriate plans of care for individual children and their families. The plans of care they develop constitute “medical necessity” for Medicaid purposes.

---

## ► Incorporate Risk-Based Financing Strategies for Children and Youth with Intensive Needs

Most of the sites use some type of risk-based financing and various risk adjustment strategies for children and youth with complex needs. **Arizona** contracts with four Regional Behavioral Health Authorities and finances them with capitation rates; higher, risk adjusted rates are provided for children in state custody. **Hawaii's** system of care (operated by the Child and Adolescent Mental Health Division) receives a case rate from Medicaid for each child with a serious emotional disorder deemed eligible for services. **Central Nebraska** uses case rate financing, with differential case rates based on the target population and a risk pool to protect against higher than anticipated expenses. **Choices** has a case rate structure with four tiers, based on youth with different levels of need, and **Wraparound Milwaukee** receives risk adjusted capitation rates from Medicaid and case rates from the child welfare and juvenile justice systems.

### **AZ** Arizona

#### ***Using Capitation Financing and Risk Adjusted Rates***

The **Arizona** State Medicaid agency contracts with the Arizona Department of Health Services (ADHS), Division of Behavioral Health Services (BHS), to manage a behavioral health carve-out. ADHS/BHS, in turn, contracts with four Regional Behavioral Health Authorities (RBHAs), covering six geographic areas throughout the state, and two Tribal Behavioral Health Authorities (TRBHAs). Arizona has a population of about six million, with nearly two million children under 18 (about 32%). Maricopa County (Phoenix) has most of the state's population, with over 3.5 million total and 1.2 million children under 18 (34%). At the time of the site visit, the RBHA in Maricopa County was Value Options (VO), a commercial behavioral health managed care company. RBHAs receive a capitation for Medicaid and State Children's Health Insurance (S-CHIP) covered services; they also receive state general revenue dollars and federal mental health and substance abuse block grant monies to provide services to non-Medicaid/S-CHIP populations and to pay for non-covered services.

There are risk-adjusted capitation rates for children in state custody that are nearly 20 times higher than for other children. In Maricopa County, the capitation rate for children in custody is \$600 per member per month (pmpm); for other children, the rate is \$35 pmpm. The rate was determined by projecting the number of children in child welfare expected to use therapeutic foster care, the number expected to use counseling services, and the number expected to use residential treatment and group home care. Case rates (i.e., population-based financing strategies) are not used in the behavioral health system.

**HI** Hawaii***Using Case Rates***

Medicaid pays a case rate of \$542 per child per month if the child meets the definition and is enrolled in mental health services. There are interagency provisions for reconciliation to the federal share of cost at the end of each fiscal year (because this rate is acknowledged up-front as too low). Determination of eligibility is made by the Child and Adolescent Mental Health Division (CAMHD) Medical Director, based on guidelines in the memorandum of understanding (MOU) between CAMHD and the state Medicaid agency. Eligibility is based on criteria, including an Axis 1 Diagnosis and a CAFAS score of 80, though there is some flexibility allowing youth to become eligible provisionally with a CAFAS score as low as 50. Each child is reviewed by a psychiatrist at the Family Guidance Center and the CAMHD Medical Director reviews and approves each case. This process was developed in response to a concern of the Medicaid agency regarding the potential for over-identifying children as having serious emotional disorders and qualifying for this case rate. Concern about the case rate possibly being too low has been expressed, although it is a Medicaid-only financed case rate and does not include the multiple funding sources that finance children's behavioral health services in the state. The state has attempted analyses on service utilization and costs; however, the population size is small and it was, therefore, difficult to obtain defensible utilization and cost data only on the Medicaid-eligible population of children with serious disorders. The state plans to attempt new analyses.

**NE** Central Nebraska***Using Case Rates and a Risk Pool***

**Central Nebraska** utilizes a case rate of \$2,136.53 per child per month for the children in state custody who are served by the Integrated Care Coordination Unit (ICCU). This rate does not include treatment costs paid for by Medicaid; it includes placement costs and support services that are not covered by Medicaid. Central Nebraska also uses a case rate of \$698.75 per child per month for children in the Professional Partner Program (PPP). The majority of placement costs are not included in the PPP case rate, however, this is an early intervention strategy targeted to children who have not yet had considerable "deep-end" service involvement. State administrators have the responsibility to determine whether the case rates are sufficient and to make adjustments if they are not; the case rate has remained at the same level for the past five years.

Region 3 Behavioral Health Services (BHS) has applied other managed care principles to operating its system of care. They have an operating reserve and a risk pool for ICCU. The risk pool is 10% of the annual case rate revenue. The pool was established for children whose expenses are higher than the revenue from the case rate. However, Region 3 BHS must use its current revenue to replace any funds it spends from the risk pool, so the Region does not tend to tap into the risk pool. The operating reserve is one month's case rate (e.g., 220 youth x amount of case rate). It is intended to cover the cost of wrapping up the program in the event the State would decide not to continue its partnership with Region 3 BHS, or if funds were not available to continue the ICCU. Region 3 BHS also reinvests costs savings, as stipulated in the cooperative agreement. Thus, when the risk pool is fully funded, and they achieve a cost savings, these savings are reinvested in either programs and services for earlier intervention (to prevent youth from becoming state wards) or is used to expand the program to serve more children who are already in custody.

**Choices Choices*****Using Tiered Case Rates***

**Choices** uses a case rate approach in Marion County, Indiana and Hamilton County, **Ohio**. A tiered case rate structure accounts for differences in anticipated level of service need. In 2007, **Indiana** adopted a four-tiered case rate system, with matching eligibility that embeds the Child and Adolescent Needs and Strengths (CANS) instrument into the eligibility and referral process. At the highest level, the case rate is approximately \$6,500 per child per month. Youth in this group are likely to require residential treatment facilities. A certain number of youth (140) must be in this highest level of care in order to offer the rate, based on the assumption that some youth will require expensive out-of-home care, while others will be served with less costly alternatives. Without the variance in cost created by the volume of youth served, the cost of this highest tier would increase. The second-level tier case rate is approximately \$4,290 per child per month, considered to be for youth in out-of-home placement or at risk of placement. The third tier case rate of \$2,780 is intended to support community-based care, without residential treatment, therapeutic foster care or hospitalization. The lowest tier case rate is approximately \$1,565 per child per month, intended for youth with less intense service needs and lower levels of risk and which is intended to cover care coordination and home-based supports through flexible funds.

The addition of tiers adds complexity to the case rate approach in terms of determining which tier is the most appropriate for a child referred for services. The temptation among referring agencies is to believe that a child fits within the lower rate categories. However, to achieve the volume needed within each tier to provide sufficient resources for services across all three tiers (similar to insurance premiums), Choices must “manage” the tiered rate structure carefully. A matrix with criteria for determining the appropriate case rate tier for children was developed. The financial viability of the tiered case rate structure is dependent upon “volume purchasing.” With enough youth served, the case rate dollars will be sufficient to account for the percentage of youth who will need costly residential care.

The tiered case rates establish a fixed and predictable cost for payers and allow greater flexibility in using funds for individualized services. The case rate is given to a fiscal intermediary (Choices) to cover the costs of treating all children in care, regardless of actual utilization. Thus, the fiscal intermediary holds the risk and is incentivized to manage care in a way that keeps the average cost of treating the population in services at or below the aggregate of the case rates. The child and family team approach is seen as the key ingredient to achieving cost containment balanced with effective results. Monthly feedback on the service package allows an opportunity for immediate adjustment to services, discarding ineffective directions and implementing new, more effective approaches.

**Wraparound Milwaukee** **Wraparound Milwaukee*****Using Risk Adjusted Capitation Rates and Case Rates***

**Wraparound Milwaukee** is a specialty service delivery system for youth with serious emotional disorders. As such, it receives a risk-adjusted capitation rate for youth with serious emotional disorders from the state Medicaid agency for the population it serves (\$1,589 per child per month), higher than the rate paid to other entities serving the Medicaid population in general. It also receives case rates from child welfare and juvenile justice (average of \$3,900 per child per month). The capitation rate was developed by an actuary who looked at utilization and expenditures for 200 “high utilizing” children in each of two years for mental health care paid for by Medicaid and then gave Wraparound Milwaukee 95% of that for the capitation. The child welfare case rate was determined by looking at what child welfare was spending on residential treatment; that amount was reduced by 40% to comprise the case rate, on the basis of more children remaining at home and/or staying in residential treatment centers (RTCs) for shorter periods of time and the costs of the home and community-based care that Milwaukee would provide.

Wraparound Milwaukee maintains auditable trails for its different funding streams. It reports that the state Medicaid audit has shifted over time from a traditional audit focused on episodes of care and case record reviews to one that is process and outcomes-oriented, looking at whether youth have child and family teams and integrated plans of care, what outcomes youth are experiencing, the adequacy of the provider network, and the like.

There is not a risk sharing pool connected to Wraparound Milwaukee, but the program can roll dollars over into the next fiscal year, and it can defer billing because billing can be done up to a year after the service is provided.



---

## E. Increase Flexibility of State and/or Local Funding Streams and Budget Structures

**Strategies include:**

- incorporating flexibility at state and local levels in the use of funding streams to finance services and supports

### ▶ Incorporate Flexibility at State and Local Levels in Use of Funding Streams to Finance Services and Supports

Flexible use of resources is an important element in financing systems of care and services. In **Hawaii**, local lead agencies (Family Guidance Centers) have significant flexibility in the use of resources and the child and family teams determine how resources will be used for each individual child and family. Similarly, **Vermont** incorporates local flexibility in the use of resources for local lead agencies and child and family teams. **Arizona, Central Nebraska, Choices, and Wraparound Milwaukee** use managed care approaches and managed care financing mechanisms (capitation and case rates) which allow for the flexible use of resources to meet individual needs.

#### **HI** Hawaii

##### ***Incorporating Local Flexibility***

At the state level, **Hawaii** is able to move funds across budget categories in mental health (e.g., from out of home to community-based services), move funds across fiscal years in Medicaid and Title IV-E, move some funds across systems with memoranda of understanding, and utilize savings in one budget category to fund increases in another within mental health (e.g., residential to intensive community-based services, as long as the bottom line is not affected).

At the local level, communities (primarily Family Guidance Centers as the primary provider agencies) have significant flexibility in the use of resources. Child and family teams decide how resources are spent on an individual case basis, with significant flexibility in how resources within the mental health budget are used. The only restriction is the requirement to answer a series of questions prior to sending a child to the mainland for treatment.



**VT Vermont**

***Incorporating Local Flexibility***

**Vermont's** system incorporates flexibility at state and local levels in the use of funding streams to finance services and supports. The individual treatment team in the local lead agency assesses needs, determines the service plan and identifies the resources that fit based on fund requirements. While specific funding sources maintain their budget identity (have appropriate identifying codes used for reporting and monitoring purposes at local and state levels), local agencies have the authority to decide and utilize budget resources to deliver the individual plan. Medicaid is the principal funding source with wide application, and most services are covered under that stream. For those services that cannot be covered using Medicaid, local agency staff considers an array of options that include other federal and state funding sources. Depending on governing statutes and agreements, funds may be moved and used across child-serving systems (e.g., the Department for Children and Families funds mental health for early intervention and crisis prevention services); savings realized in one category support other services, as is the case with the Home and Community-Based Services Medicaid waiver; and the use of state dollars as flexible funding.

**AZ Arizona, NE Central Nebraska, Choices Choices, and Wraparound Milwaukee Wraparound Milwaukee**

***Incorporating Flexibility through Managed Care Approaches and Financing***

Flexibility due to managed care approaches with capitation and case rate financing:

- **Arizona** stakeholders maintain that they have flexibility because of the managed care structure, which eliminates rigid budget categories across Medicaid, mental health and substance abuse block grant and state general revenue funds and gives Regional Behavioral Health Authorities flexibility.
- In **Central Nebraska**, the case rate structure provides flexibility at the system level in how funds are expended and at the practice level to allow the flexible use of funds to meet individualized needs of children and families and to fund services/supports that are not reimbursable with more traditional funding streams.
- In **Choices**, the case rate financing approach allows considerable flexibility in the use of funds from multiple funding streams.
- **Wraparound Milwaukee's** blended funding, supported by capitation and case rate approaches, allows for considerable flexibility in use of multiple funding streams.

---

## F. Coordinate Cross-System Funding

**Strategies include:**

- Coordinating funding across child-serving systems at the system level
- Coordinating the procurement of services and supports across agencies

### ► Coordinate Funding Across Child-Serving Systems at the System Level

The sites use various mechanisms to coordinate funding across child-serving systems. In **Hawaii**, memoranda of understanding have been negotiated between the mental health system and the Medicaid agency, as well as with the child welfare, education, and juvenile justice systems. **Vermont** enacted legislation mandating interagency coordination and establishing local and state interagency teams that address the coordination of resources and services.

#### **HI** Hawaii

##### ***Implementing Memoranda of Understanding***

Memoranda of Understanding (MOUs) help with coordination of funding across systems. For example, the child welfare and mental health systems have agreements in place regarding Title IV-E funds, including an agreement that allows a child in therapeutic foster care to remain in the same placement to avoid a disruption and maintain treatment gains, even after their needed level of care may not be as intensive. An MOU with the state Medicaid Agency (Med-Quest) gives responsibility and resources to the Child and Adolescent Mental Health Division (CAMHD) for providing intensive mental health services to eligible children and adolescents through the Support for Emotional and Behavioral Development (SEBD) program. An MOU with the Department of Education clarifies responsibilities for service delivery and financing between the children’s mental health and the education systems. An MOU with the Judicial Circuit Court (Family Court) provides resources for CAMHD to provide professional staff and mental health services at juvenile justice facilities (including consultation to facility, court staff and officers) through CAMHD’s Family Court Liaison Branch.

The success of coordinating services and funding on an individual child level depends in large part on how well the child and family team functions. The most difficult decisions regarding services and financial responsibility can be “bumped up” to higher levels in the agencies; these decisions typically are related to responsibility for payment for residential placements where there may still be lack of clarity regarding responsibility for providing and paying for specific services.

Cross-agency training is provided to the education and child welfare systems regarding the SEBD program, system responsibilities, and coordinating services and resources. There are interagency MOUs and some funding for cross-agency training (Title IV-E resources).

CAMHD also has a Resources Development Section that is responsible for developing, managing, and coordinating federal revenues such as Title XIX and Title IV-E. This section collaborates with other state agencies to maximize federal revenues and to generate reimbursement and savings for CAMHD.

Local coordinating bodies (Community Children’s Councils [CCCs]) were created as part of the Felix Consent Decree to give communities a voice in the children’s mental health system. They are comprised of families, providers, and others who serve on a volunteer basis to assess local needs, coordinate activities, and provide input on state-level policies. There are 17 CCCs across the state. A state-level coordinating body is housed in a separate office of the Department of Education. Quarterly statewide meetings of CCCs are held. The CCCs’ current role focuses on accountability/ quality assurance and advocacy.

## **VT Vermont**

### ***Enacting Legislation Mandating Interagency Coordination***

The system of care has as a fundamental goal, structure and functions to coordinate services and financing to meet the needs of the child and family. Many vehicles support that effort: Act 264, with mandated Local Interagency Teams (LIT) and a State Interagency Team (SIT) and a statutory, appointed state board that advises agency commissioners; interagency expenditure plans; interagency memoranda of understanding (these have expanded since the System of Care Plan began); a joint vision statement by the umbrella agency of human services and the Department of Education; cross-agency training and continuing education.

The LIT assists treatment teams to reach consensus on or find ways to implement a child’s coordinated service plan when they need extra support. It may review a plan and make recommendations on the content of the treatment plan; suggest possible additional resources or support to implement the plan; recommend that an agency waive or modify a policy; or, if necessary, refer the situation to the SIT for further consideration. Each LIT has a coordinator based at the local mental health center. If the LIT cannot resolve a problem or assist adequately, the SIT is a state level forum for the next round of consideration. Its role and objectives are to:

- Assist LITs to implement coordinated service plans. They may review a plan and make recommendations on content; suggest possible additional resources to help implement the plan; and/or recommend that an agency waive or modify a policy
- Ensure the coordinated development of the system of care in the areas of service, policy, and fiscal management; and ensure that information on best practices is disseminated to agency staff and to the general community.

These teams have authority to review and make recommendations but cannot order any agency to provide services. The Vermont law provides appeal rights and a process for parties to follow. A second appeal process exists for children receiving services under IDEA.

---

## ► Coordinate the Procurement of Services and Supports Across Agencies

Strategies for coordinating the procurement of services across agencies were found in **Hawaii** and **Vermont**. Hawaii developed some uniform contracting protocols that include both performance standards and practice guidelines that are shared between the education and mental health systems. In Vermont, local lead agencies function as a network and may use uniform contracting and procurement protocols for operations and for services, working through the Vermont Council for Developmental and Mental Health Services or through individual agency partnerships on specific issues. **Wraparound Milwaukee** has centralized the procurement of residential treatment services.

### HI Hawaii

#### ***Developing Uniform Contracting Protocols***

There are some uniform contracting protocols comprised of performance standards and practice guidelines that are shared between the education system and the children's mental health system. In addition, the Department of Health (DOH) and Department of Education (DOE) jointly developed a manual detailing interagency performance standards and practice guidelines for use by DOH and DOE personnel and contracted providers when developing and implementing individualized service plans for youth and their families. These standards and guidelines are designed to define services and improve the effectiveness of both school-based mental health services and the intensive mental health services provided through CAMHD's system of care.

### VT Vermont

#### ***Using Uniform Contracting and Procurement Protocols***

**Vermont's** system of care utilizes purchasing collaboratives, joint procurement practices, uniform contracting protocols, and a uniform rate structure to coordinate procurement of services and supports. Vermont's local Designated Agencies (DAs) for the provision of community mental health services operate as a preferred provider network in the state and work together in a consortium through the Vermont Council for Developmental and Mental Health Services and with the Department of Mental Health to address service and business issues. They share the same basic contract and operate as a full group or in sub-groups. They use the same protocols to make purchases for operations (relevant services, information technology, and material items). Various DA leadership groups (CEOs, CFOs/business directors) meet regularly to discuss issues under their purview. They have, for example, discussed bond issues for capital improvements and service expansions, as well as negotiated a master contract with all Agency of Human Services' departments.

**Wraparound Milwaukee** **Wraparound Milwaukee**

***Using Centralized Procurement for Residential Treatment***

*Wraparound Milwaukee*, in effect, has eliminated the practice of individual child-serving systems purchasing residential treatment on their own. Procurement of services for the populations needing this level of care is done through Wraparound Milwaukee.

**G. Incorporate Mechanisms to Finance Services for Uninsured and Underinsured Children and their Families**

***Strategies include:***

- Financing services for uninsured and underinsured children and their families
- Incorporating strategies to access services without custody relinquishment
- Encouraging private insurers to cover a broader array of services and supports

▶ **Finance Services for Uninsured/Underinsured Children and their Families**

*Hawaii, New Jersey, Arizona, and Central Nebraska* have implemented strategies to finance services for uninsured and underinsured children and their families.

**HI Hawaii**

***Using General Revenue to Finance Services for Uninsured/Underinsured and Allowing Families to Buy Into Medicaid***

Recently, *Hawaii* added a mechanism to fund behavioral health services through general revenue funds in the category of “mental health only.” This category was created to serve youth not eligible for services through other mechanisms, but who are determined to be in need of mental health services by the Child and Adolescent Mental Health Division (CAMHD) Medical Director. To be eligible for this category, a child cannot be eligible for any other program — not educationally disabled and in need of services through an individual education plan (IEP), not Medicaid eligible or eligible for the Support for Emotional and Behavioral Development (SEBD) plan through Medicaid, and not incarcerated. The population includes youth found eligible by their schools for Section 504 of the Rehabilitation Act, uninsured youth, youth who may have lost Medicaid eligibility due to incarceration or furlough, and youth with private insurance but with uncovered service needs. CAMHD serves these youth with general funds that are legislatively appropriated. If found eligible, a child can then access services that are paid by general revenue funds. The CAMHD Medical Director makes service decisions and

can authorize necessary services for children with serious emotional disorders. The entire range of services can be authorized with no predetermined limits, though the overall availability of funds is limited. If the child has private insurance, attempts are made to bill insurers for covered services; however, the state’s insurance parity law does not apply to childhood diagnoses so that many children’s mental health services are not covered by private insurance plans.

In addition, the state Medicaid program allows families above the eligibility level to buy into the Medicaid program.

## **NJ** New Jersey

### ***Establishing Eligibility as a “Children’s System of Care Child”***

The children’s system of care initiative allows for presumptive eligibility for children needing behavioral health care if they are Medicaid eligible or eligible for **New Jersey’s** S-CHIP program (New Jersey Family Care). In addition, children are eligible as a “children’s system of care child,” a child who has a serious emotional disorder and is involved or at risk for involvement in multiple systems. Regardless of whether the child is eligible for the system of care through a Medicaid or non-Medicaid eligible route, and regardless of the other systems in which the child may be involved (e.g., child welfare or juvenile justice), he/she is assigned a “system of care” identifier number that is tracked through the state Medicaid agency’s management information system.

In addition, the state allows for designation of a child with a serious disorder as a “family of one” to qualify for Medicaid-reimbursed residential treatment services.

## **AZ** Arizona and **NE** Central Nebraska

### ***Using Sliding Fee Scales and State Funds***

- In **Arizona**, Regional Behavioral Health Authorities (RBHAs) are required to screen families for implementing sliding fee scales, and they receive state general revenue and mental health/substance abuse block grant funds which they can use to serve children not eligible for Medicaid or S-CHIP. These dollars make up about 8-10% of the total funding for the system. Arizona also uses the “family of one” option, which, according to Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/BHS), can give a child 5-6 months of Medicaid eligibility even if he/she is not in an out-of-home setting that entire time.
- In **Central Nebraska**, the Professional Partner Program includes flex funds that can be used to pay for treatment when a family does not have access to a third party payer (Medicaid, private insurance or Kid Connection — Nebraska’s S-CHIP). When care coordinators request flexible funds, they must show how using the funds will lead to specific outcomes. Families are not charged to participate in the Professional Partners Program or Integrated Care Coordination program. Region 3 Behavioral Health Services (BHS) offers a sliding fee scale to assist families in paying for specific treatment services.

## ► Incorporate Strategies to Access Services without Custody Relinquishment

**Vermont** has enacted legislation that prohibits custody relinquishment for the purpose of obtaining needed mental health care. In **Central Nebraska**, a wraparound approach to services is used to work with youth and families to avoid placing youth in state custody; voluntary placement agreements are used when necessary.

### **VT** Vermont

#### ***Enacting State Statutes to Prohibit Custody Relinquishment for Services***

**Vermont** statute [Title 33 Human Services §4305(g)] prohibits requiring custody relinquishment in order for parents to obtain mental health care for their children. In addition, years ago, state level data analysis revealed that a significant percentage of children in parental custody would experience a “crisis,” and then be admitted to state custody on an Emergency Detention Order (EDO) as a child in need of supervision (CHINS). These children then would emerge from state custody within 30 days once the “crisis” was understood and a plan of supports and services was developed and begun. To prevent families from having to relinquish custody in these situations, the state initiated a major effort, supported by a federal grant, to re-think “crisis” response services. Significant reductions in EMOs for CHINS have occurred and been sustained over the last decade.

### **NE** Central Nebraska

#### ***Implementing Wraparound Approach to Prevent Custody Relinquishment***

The mission of the Early Intensive Care Coordination Program (EICC) is to use the wraparound approach and family-centered practice to coordinate services and supports for families whose children are at risk of being placed in state custody and to ensure that families have a voice, ownership and access to a comprehensive, individualized family support plan. Of the 67 children served in EICC during fiscal year 2005, 88.1% were prevented from being placed in the state’s custody. Families in Region 3 rarely transfer custody of their children to access services. When children do need to be placed to access treatment services, a voluntary placement agreement will be pursued, rather than involving the court. The Office of Protection and Safety and Region 3 Behavioral Health Services (BHS) work together to determine how to avoid inappropriate custody relinquishment. Some respondents indicate that additional care coordination services are needed statewide. Nebraska’s Child and Adolescent State Infrastructure Grant has formed a subcommittee to gather more data on the custody relinquishment issue and reintroduce legislation that did not pass previously. (Note: Since the site visit, **Central Nebraska** has been unable to continue its EICC Program due to state policy changes limiting the use of funds to children who are currently in state custody. In place of EICC, a new School-Based Intervention Program for children and youth in custody is being implemented.)



---

## ► Encourage Private Insurers to Cover a Broader Array of Services and Supports

*Hawaii* attempts to bill private insurers for covered services and, in addition, has had preliminary talks with Blue Cross about allowing their insured access to the Child and Adolescent Mental Health Division (CAMHD) service array. *Vermont* enacted a parity law requiring health plans to cover mental health and substance abuse services to the same extent as other health services.

### **HI** Hawaii

#### ***Billing Private Insurers***

Under the “mental health only” category, if the child has private insurance, attempts are made to bill insurers for covered services; however, the state’s insurance parity law does not apply to childhood diagnoses so that many children’s mental health services are not covered by private insurance plans.

Blue Cross has approached the state to allow some of their covered lives to access the Child and Adolescent Mental Health Division (CAMHD) service array. The state is attempting to determine how to bill the insurance company for services and to build the capacity to do so. Concern has been expressed that the state’s children’s mental health system could become a provider for families with insurance, and would, therefore, have diminished capacity to serve uninsured children and families. This has led to a discussion on the mission and role of the public mental health system. This is still being worked on at present.

### **VT** Vermont

#### ***Enacting Parity Legislation***

*Vermont’s* mental health parity law, which went into effect in January 1998, requires health insurance plans to cover mental health and substance abuse services at no greater cost to the consumer than insurance for other health services. The law eliminates separate and unequal deductibles and out-of-pocket costs for mental health and substance abuse services. The law applies to all health plans offered by Vermont insurance companies, including health maintenance organizations (HMOs), but it does not apply to self-insured plans. It requires a single deductible and the same out-of-pocket co-payments or co-insurance for mental health and substance abuse services and all other covered health services. It also removes separate yearly and lifetime visit limits and dollar maximums. State leaders acknowledge that the law has been significant in helping to change some practice and to continue calling attention to disparities. They point out that there are still a lot of loopholes for private insurers that are not based in Vermont.

In 2006 Vermont passed a law that establishes a new state-funded insurance program for the uninsured, called Catamount Health, which requires employers to pay assessments if they do not offer health care coverage to their workers. (This program will provide individual adult and family coverage for those not eligible for Medicaid and its extended programs; children and adolescents are already covered under the Vermont Medicaid “Dr. Dynasaur” program up to 300% of the federal poverty level.)

---

## III. Financing of Appropriate Services and Supports

By definition, systems of care include a comprehensive array of services and supports to meet the multiple and changing needs of children and adolescents with emotional disorders and their families. Financing to cover this broad array of both clinical and supportive services is a fundamental requirement. The system of care philosophy and approach also emphasizes an individualized approach to service delivery, such that the needs, strengths, and preferences of the youth and family dictate the types, mix, and duration of services and supports. Thus, in addition to financing that covers a broad service array, financing mechanisms must support and promote individualized, flexible service delivery. Financing strategies also are needed to support the incorporation of evidence-based and promising practices to improve the effectiveness of services, mental health services to young children and their families, early identification and intervention, and the coordination of services across child-serving agencies and systems.

### Financing Strategies Include:

**A. Provide a Broad Array of Services and Supports**

**B. Promote Individualized, Flexible Service Delivery**

**C. Support and Provide Incentives for Evidence-Based and Promising Practices**

**D. Promote and Support Early Childhood Mental Health Services**

**E. Promote and Support Early Identification and Intervention**

**F. Support Cross-Agency Service Coordination**

## A. Provide a Broad Array of Services and Supports

### **Strategies include:**

- Covering a broad array of services and supports through Medicaid and other funding streams

### ► **Cover a Broad Array of Services and Supports through Medicaid and Other Funding Streams**

The study examined coverage of the array of services and supports shown below on **Table 3**. All of the sites studied cover virtually all of these services and supports and, often, additional services and supports, such as supported employment, peer support, traditional healing, flexible funds, respite homes, respite therapeutic foster care, supported independent living services, intensive outpatient services, treatment/service planning, parent skills training, ancillary support services, family and individual education, consultation, peer support, emergency/hospital diversion beds, after school and summer programs, substance abuse prevention, youth development, and mentor services. These services and supports typically are covered using Medicaid and a variety of additional financing streams from mental health and other child-serving systems.

<b>Nonresidential Services</b>	<b>Residential Services</b>	<b>Supportive Services</b>
<ul style="list-style-type: none"> <li>• Assessment and diagnostic evaluation</li> <li>• Outpatient therapy—individual, family, group</li> <li>• Medication management</li> <li>• Home-based services</li> <li>• School-based services</li> <li>• Day treatment/partial hospitalization</li> <li>• Crisis services</li> <li>• Mobile crisis response</li> <li>• Behavioral aide services</li> <li>• Behavior management skills training</li> <li>• Therapeutic nursery/preschool</li> </ul>	<ul style="list-style-type: none"> <li>• Therapeutic foster care</li> <li>• Therapeutic group homes</li> <li>• Residential treatment center services</li> <li>• Inpatient hospital services</li> </ul>	<ul style="list-style-type: none"> <li>• Care management</li> <li>• Respite services</li> <li>• Wraparound process</li> <li>• Family support/education</li> <li>• Transportation</li> <li>• Mental health consultation</li> </ul>

---

## **AZ** Arizona

### ***Covering a Broad Array of Services and Supports***

In **Arizona**, services are financed primarily by Medicaid dollars through the behavioral health managed care system. The managed care system covers a very broad array of services and supports. Arizona has used the JK lawsuit to expand the array of covered services under Medicaid and redirection of spending from out-of-home to home and community based services to expand availability of these covered services. The managed care system also includes state general revenue and block grant dollars, in addition to Medicaid and S-CHIP, which can be used to pay for services that are not covered within the Medicaid benefit. For example, non-Medicaid dollars can be used to pay for traditional Native healers. The array of covered services includes:

- Behavioral counseling and therapy
- Assessment, evaluation and screening
- Skills training and development and psychosocial rehabilitation skills training
- Cognitive rehabilitation
- Behavioral health prevention/promotion education and medication training and support services
- Psychoeducational services and ongoing support to maintain employment (supported employment)
- Medication services
- Laboratory, radiology and medical imaging
- Medical management
- Case management
- Personal care services
- Home care training family (Family support)
- Self-Help/Peer services (Peer support)
- Therapeutic foster care
- Unskilled respite care
- Supported housing
- Sign language or oral interpretive services
- Non medically necessary services (flex fund services)
- Transportation
- Mobile crisis intervention
- Crisis stabilization
- Telephone crisis intervention
- Hospital
- Subacute facility
- Residential treatment center
- Behavioral health short-term residential, without room and board
- Behavioral health long term residential (non medical, non acute), without room and board
- Supervised behavioral health day treatment and day programs

- Therapeutic behavioral health services and day programs
- Community psychiatric supportive treatment and medical day programs
- Prevention services
- MST, FFT, ACT teams
- Traditional healing (non Medicaid funds)
- Flex funds for discretionary services (these are small — about \$850,000 statewide)

Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/BHS) is trying to get telephone consultation covered under Medicaid and just completed a white paper on the issue for Medicaid (e-mail consultation is covered).

For a complete description of Arizona's covered services, see the state's Covered Behavioral Health Services Guide, available at: [http://www.azdhs.gov/bhs/bhs\\_gde.pdf](http://www.azdhs.gov/bhs/bhs_gde.pdf). Appendix B2 to the guide describes provider types and fee for service rate guidance, available at: [http://www.azdhs.gov/bhs/app\\_b2.pdf](http://www.azdhs.gov/bhs/app_b2.pdf).

## **HI** Hawaii

### ***Covering a Broad Array of Services and Supports***

All services in the chart are covered under Medicaid, with match from mental health general funds. Mental health services at lower levels of intensity are provided through the education system through school-based mental health service delivery approaches (School-Based Behavioral Health Services and Supports [SBBH]). If the need for more intensive services is identified, the youth is referred to the Family Guidance Center in his/her area. These youth are enrolled in the Educationally Supportive (ES) Intensive Mental Health Program (they generally are IDEA-eligible and have an individual education plan (IEP) with a recommendation for mental health services from the Child and Adolescent Mental Health Division [CAMHD]). Medicaid-eligible youth may also receive basic mental health services from their Quest health plan. If they require mental health services that exceed the scope and intensity that can be provided by their health plan, they are enrolled in the Support for Emotional and Behavioral Development (SEBD) program (criteria include Medicaid eligibility, a DSM IV diagnosis of at least six months, and a CAFAS or PECAFS score of 80 or greater, with eligibility determined by the CAMHD Medical Director).

CAMHD's website describes its service array as including: Emergency Crisis Intervention Services — 24-hour crisis telephone stabilization, mobile crisis outreach, residential crisis stabilization; Intensive Care Coordination, which is provided by CAMHD mental health care coordinators (MHCCs) located in Family Guidance Centers (intensive clinical case management); Intensive Treatment Services, which are intensive home and community-based interventions, Multisystemic Therapy

---

(MST); and Community-Based Treatment Services including therapeutic foster homes, therapeutic group homes, community-based residential programs, and hospital-based residential programs. CAMHD's service array is described in its RFP to providers (Nov. 2005) and defined further in its Interagency Performance Standards and Practice Guidelines:

**Emergency Public Mental Health Services**

- Crisis telephone stabilization
- Crisis mobile outreach
- Crisis therapeutic foster home
- Community-based crisis group home

**Educationally Supportive Intensive Mental Health Services**

- Psychosocial assessments
- Intensive in-home intervention
- MST
- Respite therapeutic foster home
- Respite homes
- Community mental health shelter (24 hour temporary care for youth awaiting placement in an appropriate treatment facility)
- Therapeutic foster homes
- Multidimensional treatment foster care
- Therapeutic group homes
- Independent living programs (16–18 and 18–21)
- Community-based residential (Levels I, II, and III)
- Hospital-based residential (inpatient treatment)

**Support for Emotional and Behavioral Development (SEBD) Program Services**

- Comprehensive mental health assessment
- Focused mental health assessments
- Summary annual assessments
- Psychiatric evaluation
- Medication management
- Individual therapy
- Group therapy
- Family therapy
- Partial hospitalization
- Functional family therapy
- Peer support
- Parent skills training
- Intensive outpatient treatment for co-occurring substance abuse
- Intensive outpatient services for independent living skills
- Community-based clinical detoxification
- Community hospital crisis stabilization
- Acute psychiatric hospitalization

---

### **Care Coordination (not sought through RFP, provided by CAMHD personnel)**

- Mental health care coordination
- Treatment/service planning participation/IEP participation
- School consultation
- Case consultation
- Family court testimony

### **Support Services (not sought through RFP, provided by CAMHD personnel)**

- Ancillary support services
- Respite supports

## **NJ New Jersey**

### ***Covering a Broad Array of Services and Supports***

The state has expanded the services covered by Medicaid dollars as well as those covered by non-Medicaid dollars. The system design features a flexible, broad benefit plan that covers a wide array of traditional and non-traditional services. Services covered include: assessment, mobile crisis/emergency services, group home care, treatment homes/therapeutic foster care, acute psychiatric inpatient care, intensive face-to-face care management, wraparound, out-of-home crisis stabilization, intensive in-home services, psychotropic medications, medication management, behavioral assistance, and family-to-family support. The state also allows the Care Management Organizations (CMOs) to use flex funds in order to meet additional individual needs that are not met through covered services.

## **VT Vermont**

### ***Covering a Broad Array of Services and Supports***

The **Vermont** system of care includes the following services and supports, which are available regionally:

- **Immediate Response:** Each Designated Agency (DA) provides access to an immediate response service and/or short-term assistance for children and adolescents who are experiencing a crisis and their families. Crisis services are time-limited (usually up to 2–3 days) and intensive and include the following:
  - Assessment, support, and referral over the telephone
  - Crisis assessment, outreach, and stabilization face-to-face
  - Family and individual education, consultation, and training
  - Service planning and coordination
  - Screening for crisis bed (hospital diversion) and for inpatient psychiatric hospitalization



- **Clinic-based Treatment:** Each DA offers clinic-based treatment services for children and families. These services are available during daytime and evening hours for school-age children and/or when families can easily access them. The intensity of the service is based on the needs of the child and family, and the family's request for one or more the following elements:
  - Clinical assessment
  - Group, individual, and family therapies
  - Service planning and coordination
  - Medication services
- **Outreach Treatment:** Each DA offers outreach treatment services for children and families. These services are available in the home, school, and general community settings. The intensity of the service is based on the needs of the child and family and the family's request for one or more the following elements:
  - Clinical assessment
  - Group, individual and family therapies
  - Service planning and coordination
  - Intensive in-home and out-of-home community services to child and family
  - Medication services
  - Family and individual education, consultation, and training
- **Family Support:** Support services can be very important in reducing family stress and providing parents and caregivers with the guidance, support, and skill to deal with a difficult-to-care-for child. Each DA provides and/or has direct community connections to support services for families and youth. These services are offered in partnership with parents and consumer advocates. Participation in one or more of the following support services is voluntary and based on the family's needs and desires:
  - Skills training and social support
  - Peer support and advocacy
  - Respite
  - Family and individual education, consultation, and training
- **Prevention, Screening, Referral and Community Consultation:** The goal is to provide prevention for all by: promoting healthy development, increasing protective factors and reducing risk factors; early screening and intervention activities for those at risk; and, community consultation activities for non-mental health professionals, community groups, and the public.
- In addition, the following services are available statewide:
  - Emergency/Hospital Diversion Beds
  - Intensive Residential Services
  - Hospital Inpatient Services

---

## **NE** Central Nebraska

### ***Covering a Broad Array of Services***

During fiscal year 2005, Region 3 Behavioral Health Services (BHS) expended a total of \$6,313,638 for the purchase of services for children and families, intensive case management, youth leadership, family empowerment, evaluation and system coordination activities. Region 3 BHS contracts with a network of providers that offer the following services and supports for children and their families:

- 24 hour crisis services
- Mobile crisis services
- School-based outpatient family education, information, support and advocacy
- Family care partners
- Youth Encouraging Support (YES)
- Children's day treatment
- Medication management
- Mental health outpatient therapy
- Multi-Systemic therapy
- Crisis inpatient services
- Substance abuse outpatient therapy
- Youth assessment (SA)
- Adolescent intensive outpatient
- Respite

#### **Region 3 BHS provides directly:**

- Professional partner program
- Integrated care coordination unit
- Early intensive care coordination (wraparound model)
- Alcohol, tobacco and other drug abuse prevention
- Mentor services

In addition to the services listed above that are provided or purchased by Region 3 BHS, specific treatment services for Medicaid-eligible children and families are authorized by Magellan, the statewide Medicaid behavioral health managed care organization. These include therapeutic foster care, therapeutic group homes, residential treatment centers, inpatient hospital services, case management services, transportation, and mental health consultation.

**Choices Choices**

**Covering a Broad Array of Services and Supports**

**Choices** provides a broad array of services and supports, covered under the case rate structure in all the communities served. In addition to the services and supports, there are 11 different categories of flexible funds, which allows for creative service delivery and the provision of whatever services and supports may be needed by the youth and family.

Service Array			
Behavioral Health	Psychiatric	Mentor	Placement
<ul style="list-style-type: none"> <li>• Behavior management</li> <li>• Crisis intervention</li> <li>• Day treatment</li> <li>• Evaluation</li> <li>• Family assessment</li> <li>• Family preservation</li> <li>• Family therapy</li> <li>• Group therapy</li> <li>• Individual therapy</li> <li>• Parenting/family skills training</li> <li>• Substance abuse therapy, individual and group</li> <li>• Special therapy</li> </ul>	<ul style="list-style-type: none"> <li>• Assessment</li> <li>• Medication follow-up,</li> <li>• Psychiatric review</li> <li>• Nursing services</li> </ul>	<ul style="list-style-type: none"> <li>• Community case management/case aide</li> <li>• Clinical mentor</li> <li>• Educational mentor</li> <li>• Life Coach/independent</li> <li>• Living skills mentor</li> <li>• Parent and family mentor</li> <li>• Recreational/social mentor</li> <li>• Supported work environment</li> <li>• Tutor</li> <li>• Community supervision</li> <li>• Intensive supervision</li> </ul>	<ul style="list-style-type: none"> <li>• Acute psychiatric hospitalization</li> <li>• Foster care — non therapeutic</li> <li>• Therapeutic foster care</li> <li>• Group home care</li> <li>• Relative placement</li> <li>• Residential treatment</li> <li>• Shelter care</li> <li>• Crisis residential</li> <li>• Supported independent living</li> </ul>
Respite	Service Coordination	Discretionary	Other
<ul style="list-style-type: none"> <li>• Crisis respite (daily or hourly)</li> <li>• Planned respite (daily or hourly)</li> <li>• Residential respite</li> </ul>	<ul style="list-style-type: none"> <li>• Case management</li> <li>• Service coordination</li> <li>• Intensive case management</li> </ul>	<ul style="list-style-type: none"> <li>• Activities</li> <li>• Automobile repair</li> <li>• Childcare/supervision</li> <li>• Clothing</li> <li>• Educational expenses</li> <li>• Furnishings/appliances</li> <li>• Housing (rent, security deposits)</li> <li>• Medical</li> <li>• Monitoring equipment</li> <li>• Paid roommate</li> <li>• Supplies/groceries</li> <li>• Utilities</li> <li>• Incentive money</li> </ul>	<ul style="list-style-type: none"> <li>• Camp</li> <li>• Team meeting</li> <li>• Consultation with other professionals</li> <li>• Guardian ad litem</li> <li>• Transportation</li> <li>• Interpretive services</li> </ul>

## **Wraparound Milwaukee** **Wraparound Milwaukee**

### ***Covering a Broad Array of Services and Supports.***

Services are funded primarily by Medicaid, child welfare, juvenile justice, and mental health through capitation and case rate financing. **Wraparound Milwaukee** has over 200 providers (agencies and individuals) in its network, representing 85 different services and supports and including over 40 racially and culturally diverse providers. The services and supports it covers range from highly specialized clinical treatment services to nontraditional services and natural supports, including:

<b>Service Array</b>	
<ul style="list-style-type: none"> <li>• Care Coordination</li> <li>• Individual and Family Therapy</li> <li>• Substance Abuse Counseling</li> <li>• Group therapy</li> <li>• Crisis 1:1 Stabilization</li> <li>• Mentors</li> <li>• Tutors</li> <li>• Intensive In-Home Therapy</li> <li>• Psychiatric In-Patient Treatment</li> <li>• Residential Treatment</li> <li>• Group Home</li> <li>• Foster Care</li> <li>• Therapeutic Foster Care</li> <li>• Professional Foster Care</li> <li>• Medical Day Treatment</li> <li>• Crisis/Respite Group Home</li> <li>• Specialized Sexual Offender Services</li> <li>• FOCUS – Alternatives to Correctional Care</li> <li>• Medication Management</li> </ul>	<ul style="list-style-type: none"> <li>• Transportation</li> <li>• After school</li> <li>• Job coaches</li> <li>• Independent Living</li> <li>• Housing</li> <li>• Child care</li> <li>• Household management</li> <li>• Specialized educational services</li> <li>• Behavioral Aides</li> <li>• Supervised Apartments</li> <li>• Intensive In-Home Monitoring for Court</li> <li>• Discretionary funds</li> <li>• Parent Aides</li> <li>• Interpretation</li> <li>• Kinship Care</li> <li>• Rent/Food Assistance</li> <li>• Employment Training/Placement</li> <li>• Transitional care</li> </ul>

## **AK** **Bethel, Alaska**

### ***Covering a Broad Array of Services and Supports***

In addition to the mental health assessment and treatment services that are available at the village level through teams of licensed mental health professionals and behavioral health aides, the following unique services are available in Bethel and offered to youth and families throughout the YKHC region:

- **Fetal Alcohol Spectrum Disorders Diagnostic Team** — A multidisciplinary team composed of pediatricians, pediatric nurse practitioner, behavioral health clinician, Family Advocate, Clinical Psychologist, Occupational Therapist, Speech Pathologist and case manager provide diagnostic assessments for children and youth suspected of prenatal alcohol exposure.

- **Kuskokwim Emergency Youth Services** — This is a 12-bed facility that houses two emergency shelter programs. One program, a Residential Diagnostic Treatment Center, provides evaluation and short-term residential treatment for children experiencing a life crisis so disruptive that it cannot be managed in an outpatient setting. The RDT offers an alternative to hospitalization in Anchorage for many youth and has the ability to address youth and family needs in a culturally appropriate way by providing services closer to the home community, thus allowing family participation in treatment, and by primarily employing staff who are Alaska Native.
- **Inhalant Abuse Treatment Center** — This is the only residential treatment program in the nation specifically addressing the problem of inhalant abuse, offering a 14–16 week treatment program for up to six young people ages 10–17. Highlights of the program include a four-phase program starting with detoxification, then treatment. The family is integrated into all parts of the program, and the center works closely with the child’s home community to develop a network of support for the child following treatment.

## B. Promote Individualized, Flexible Service Delivery

### *Strategies include:*

- Incorporating flexible funds for individualized services and supports
- Financing staff participation in individualized service planning processes and the functions of child and family teams
- Incorporating care authorization mechanisms that support individualized, flexible service delivery

### ► Incorporate Flexible Funds for Individualized Services and Supports

Most of the sites incorporate flexible funds that can be used to pay for services and supports that are not covered by Medicaid or other sources. **Arizona, Hawaii, New Jersey, and Vermont** designate funds for this purpose. Typically, child and family teams can access these funds to provide these ancillary services and supports as needed. In other sites, such as **Central Nebraska and Wraparound Milwaukee**, the managed care financing approaches make the resources within the system inherently flexible and available to meet individualized needs. **Choices** also uses its case rate financing to provide flexible funds.

### **AZ** Arizona, **HI** Hawaii, **NJ** New Jersey, and **VT** Vermont *Using Funds Designated as “Flexible Funds”*

- The **Arizona** Department of Health Services, Division of Behavioral Health Services (ADHS/ BHS) distributes about \$850,000 in discrete flexible funding to the Regional Behavioral Health Authorities (RBHAs), using general revenue and block grant dollars. RBHAs have flexibility in how they spend these dollars for individual children. However, they are small, amounting to

---

\$23 per child per year. Value Options indicated that individualized and coordinated plans of care are facilitated primarily by the child and family team approach and not by financing or single purchasing strategies.

- In **Hawaii**, flexible funds are provided by the Child and Adolescent Mental Health Division (CAMHD) and are available to child and family teams to finance services and supports not covered by other sources. Flexible funds for “ancillary” services and supports can be used for a variety of purposes for children and their families as needed.
- In **New Jersey**, Care Management Organizations (CMOs) have allocations of flexible funds to assist in the development of individual service plans (ISPs) for the families they serve. This is done in conjunction with the child and family teams.
- In **Vermont**, flexible funds derived from mental health state general revenue dollars and federal grant funds are used to cover services and supports that are not allowable under Medicaid, the principal payer for services and supports. Decisions made by the individual child and family team and local lead agency drive the use of funds based on individual child and family needs. Many children have needs across departmental lines of responsibility and are entitled to a Coordinated Service Plan. This broadens the scope of the child and family’s plan to include both public and private services and funding resources.

## **NE** Central Nebraska and

## **Wraparound Milwaukee** Wraparound Milwaukee

### ***Using Managed Care Approaches to Provide Flexible Funds***

- **Central Nebraska’s** case rate system allows care coordinators in the Integrated Care Coordination program (ICCU) and Professional Partners Program to have access to flexible funds that can be used to meet individualized needs of children and families and to fund services/supports that are not reimbursable with more traditional funding streams. Providers noted that care coordinators in ICCUs are willing to experiment with new strategies and that services are less restricted and categorical.
- **Milwaukee’s** use of blended funding and of managed care approaches, such as capitation and case rates, and its broad, diverse provider network enable it to use funds in a flexible manner to implement an individualized approach to service delivery.

---

## **Choices** Choices

### ***Creating Categories of Flexible Funds for Discretionary Services and Supports***

The matrix listing service codes that can be provided by Dawn includes 11 categories of flexible funds, including activities, automobile repair, childcare/supervision, clothing, educational expenses, furnishing/appliances, housing, medical, monitoring equipment, paid roommate, supplies/groceries, utilities and incentive money. This demonstrates the degree of flexibility that child and family teams are given in planning services and supports that are tailored to the specific needs of each child and family. The flexible funds are used to finance supports including transportation (bus, car repairs, etc.), housing, utilities, clothing, food, summer camps (including for siblings), home repairs, and others. The expenditures must be within the care plan structure, and the plan must document how such expenditures will support the service plan goals for the child and family.

## ► **Finance Staff and Provider Participation in Individualized Service Planning Processes and the Functions of Child and Family Teams**

In addition to flexible funds, individualized care requires the convening of a child and family team that, in partnership with the youth and family, develops and implements an individualized service plan. Strategies to finance the participation of staff and providers in the individualized service planning process and on child and family teams have been implemented by the sites. In several sites (**Arizona**, **Vermont**, and **Choices**), staff can bill for time spent in child and family team processes as case management. In addition, contract providers can bill the local lead agency in Vermont or Choices for their time. **Hawaii** has a billing code for “treatment planning.” **Central Nebraska** and **Wraparound Milwaukee** use their blended resources to cover staff and provider participation.

## **AZ** Arizona

### ***Covering Provider Participation as Billable Case Management***

Child and family teams are mandated in and covered by the managed care system. The state has given direction to providers as to how to bill for child and family teams (CFTs). Essentially, the CFT process is billed as case management. Elements of the process also can be billed as assessment, transportation, family or peer support, and interpretation services. The costs of transportation for families to participate are built into the rates paid to providers, unless the distance exceeds 25 miles in which case providers can bill separately. The state Medicaid agency has been cautious about using a case rate or bundled rate for CFTs. Child and family teams are required to be held at detention for youth in detention.



---

Child welfare uses Team Decision Making (TDM) when the system is considering removal or temporary removal and has to be implemented within 48 hours. It focuses primarily on safety issues, and then a child and family may move to a CFT process in the behavioral health managed care system. Behavioral health providers expressed concern that, while they can bill for participation in CFTs, they cannot bill for participation in TDM.

## **HI** Hawaii

### ***Using Billable Code for Treatment Planning***

Child and family teams are organized as part of the Coordinated Service Plan (CSP) process. The CSP is an over arching, strengths-based plan that coordinates all services and supports for an individual child and family. Mental health care coordinators (MHCCs) play a pivotal role in service delivery by convening an initial CSP meeting and coordinating the development of the service plan. All services included in the CSP are then authorized. MHCCs are state employees who are attached to the Family Guidance Centers that are part of the Child and Adolescent Mental Health Division (CAMHD). Their lead role in individualized service planning is an integral part of their responsibilities. Many other agency staff who participate in teams are also state employees and participation is considered to be part of their role. For contract providers (such as outpatient therapists), participation in individualized service planning process is billable time under a service code for “treatment planning.” For some providers (such as intensive in-home service providers), participation in the wraparound planning process is considered part of their unit cost. Some provider agencies suggested that this creates pressure, particularly if the provider must travel to another island for the child and family team meeting. Parent partners participate in the individualized service planning process if requested by a family and are paid through a contract with the family organization that is funded through block grant dollars.

Teleconferencing is being used to a greater extent to facilitate this process; video conferencing would be helpful but the capability is not fully developed.

**VT Vermont*****Covering Provider Participation as Case Management and Individualized Service Planning***

*Vermont's* system of care provides financing via Medicaid, block grant, and general fund dollars to support staff participation in the service planning and the work of individual child and family teams. These teams have the responsibility of developing the individual service plan for the child. System of care financing supports the development of a Coordinated Service Plan, which is required by state statute for children with severe emotional disturbance and their families. Payment for participation in team planning can be billed as case management under Medicaid. In addition, provider participants not located in the Designated Agency (DA) can bill the DA for their time participating on child and family teams for individualized service planning. Family members on child and family teams may receive some support to aid participation (e.g., transportation).

**Choices Choices*****Covering Participation as Case Management and Additional Service Hours***

Participation in child and family team meetings is billable time under Medicaid for care managers. Providers participating in child and family team meetings in support of individualized services may request payment for their participation by adding extra hours onto their care authorizations. A primary role of the care coordinator is to create and convene a child and family team, which is done as soon as possible, always within 30 days of the referral, and continues to meet at least monthly thereafter. Child and family teams are comprised of all the individuals who can contribute to the child and family's services and support (parents or other caregivers, child if appropriate, care coordinator, referring worker, currently involved service providers, therapist, school representative, other natural or community supports identified by the family, e.g., minister, relative, respite provider). Team members participate in a care planning process referred to as the "strengths discovery process," used as a framework to jointly develop and reach consensus on goals and a course of action. This process involves analyzing the child and family's strengths and needs across significant life domains, including health/medical, safety/crisis, family/relationships, educational/vocational, psychological/emotional, substance abuse, social/recreational, daily living, cultural/spiritual, financial, and legal. The resources and strengths of the child and family are used as tools to create solutions and to build a "care coordination plan," which is the individualized service and support plan. The care coordination plan focuses on three to five of the identified needs determined to be the top priorities to be addressed during the next 30 days. For each need, the plan specifies desired outcomes (measurable), specific interventions (services, supports, or resources) planned to achieve the outcomes, and who is responsible for providing each of the specified interventions. A safety and crisis plan also is developed by the team and includes clear-cut instructions for what to do whenever a crisis may occur. The child and family team is responsible for reviewing and monitoring progress toward goals at least every 30 days and altering service plans and/or providers as needed.

## **Wraparound Milwaukee** **Wraparound Milwaukee**

### ***Covering Participation with Blended Funds***

Participation by clinical staff in team meetings is not a billable service for Medicaid purposes. However, **Wraparound Milwaukee** pays therapists and other staff as needed to participate in team meetings, using its other funding sources.

## ► **Incorporate Care Authorization Mechanisms that Support Individualized, Flexible Service Delivery**

A number of the sites use child and family teams as the mechanism for authorizing services. In **Arizona, Hawaii, Vermont, Choices,** and **Wraparound Milwaukee,** the plan of care developed by the child and family team determines medical necessity and all services specified by the plan are considered to be authorized.

## **AZ** **Arizona,** **HI** **Hawaii,** **NJ** **New Jersey,**

## **VT** **Vermont,** **Choices** **Choices,** and

## **Wraparound Milwaukee** **Wraparound Milwaukee**

### ***Using Child and Family Teams to Authorize Services***

- In **Arizona**, except for residential treatment, which requires prior authorization, the child and family team plan of care determines medical necessity and drives service authorization.
- In **Hawaii**, the child and family teams develop the service plan (Coordinated Service Plan), and all services in the plan are authorized; the mental health care coordinator completes needed written service authorizations. The team is the decision maker regarding care authorization.
- In **New Jersey**, the Care Management Organizations (CMOs) are responsible for the coordination of care for children with serious emotional problems and their families. To enable care managers to provide intensive care management, caseloads are capped at a ratio of one care manager to ten children. Care coordinators use child and family teams to plan and coordinate services and supports, and services included in the plan are authorized by the Contracted Systems Administrator (CSA).
- In **Vermont**, care authorization takes place at the local agency level, based on the treatment team plan. Should questions or disputes arise for children with serious emotional disorders receiving services under the system of care, the Local Interagency Team is available to assist and help achieve resolution. Further assistance may be requested of the State Interagency Team should issues remain unresolved through the local forums.
- In **Choices**, the child and family team creates a care coordination plan for each child and family. This care plan is the authorizing document, in that any service prescribed in the plan is considered to be authorized. Providers submit bills based on this authorization and are paid on a fee-for-service basis.
- In **Wraparound Milwaukee**, the child and family team, using a strengths-based, individualized approach, determines “medical necessity”, including for Medicaid purposes, and services specified by the team are considered authorized, except for inpatient hospitalization, residential treatment, and day treatment which require prior authorization.

---

## C. Support and Provide Incentives for Evidence-Based Support and Promising Practices

### ***Strategies include:***

- Incorporating financing and incentives for using evidence-based and promising practices
- Incorporating financing for development, training, and fidelity monitoring

### ► **Incorporate Financing/Incentives for Using Evidence-Based and Promising Practices and Financing for Development, Training, and Fidelity Monitoring**

The sites are involved in promoting and financing the implementation of evidence-based and promising practices. Their strategies range from establishing billing codes for specific evidence-based practices to providing financial support for the initial training and start-up or developmental costs involved in adopting evidence-based practices, and, in some cases, providing resources for ongoing training and fidelity monitoring. A range of evidence-based approaches is supported in the sites.

#### **AZ** **Arizona**

##### ***Financing Specific Evidence-Based Practices***

In addition to its commitment to fund a wraparound approach throughout the system, the system currently is also funding Multisystemic Therapy (MST), Functional Family Therapy (FFT), Multidimensional Treatment Foster Care in Maricopa County only, and Dialectical Behavior Therapy. At both the state and Regional Behavioral Health Authority (RBHA) levels, there also is interest in developing several evidence-based practices (EBPs) in the substance abuse area, including: Stages of Change, Motivational Interviewing, Seven Challenges, and the Matrix Model. The **Arizona** Department of Health Services, Division of Behavioral Health Services (ADHS/BHS) has a best practices committee structure, which includes representation from the RBHAs and families, but does not yet include the other system partners like child welfare. (This committee was in the process of being restructured at the time of the site visit.)

MST currently is funded on a single day rate of \$65/day, as a partial day program. At the time MST was instituted (2004), this was the only option for coding the service; currently, ADHS/BHS is looking at using the federal MST code. In general, rates are negotiated for each EBP, and quality supervision is built into the rate. Providers indicated that the managed care structure provides more flexibility to tailor rates to individual EBPs.

Development of EBPs is financed through ADHS/BHS, using mainly grant funding and some block grant monies, as well as by other state agencies. For example, MST and FFT were developed initially by juvenile justice, using state general revenue funds, and then these providers became part of RBHA networks. Also, the RBHAs are allowed to spend up to 7% of their budgets on administration,

---

which could include development of EBPs. ADHS/BHS, using grant dollars, has funded consultants and trainers and has subsidized providers so they can participate in training (i.e. paying them for lost billable time). Value Options (VO) indicated that because most revenue is based on actual encounters, it is difficult to find dollars for EBP development and fidelity monitoring, although VO has supported agencies in the network to develop certain EBPs, using specific contracts for that purpose.

## **HI** Hawaii

### ***Promoting the Use of Evidence-Based Practice Components and Financing Specific Evidence-Based Practices***

There are financial incentives for using evidence-based practices, including evidence-based decision-making and using practices that produce results. One of the goals in the strategic plan for 2003–2006 was to consistently apply current knowledge of evidence-based services in the development of individualized plans and to ensure that the design of the mental health system facilitates the application of these services.

The Child and Adolescent Mental Health Division (CAMHD) has an Evidence-Based Services Committee comprised of academicians, CAMHD leadership, providers, and families to review and evaluate relevant research to inform service delivery and practice development. The committee completed extensive work to identify the specific “practice components” or elements that comprise those clinical approaches that are supported by research evidence. The state is now collecting information from providers about the use of these practice components as part of the clinical intervention process in service delivery. A coding system was developed and an accompanying codebook to define and identify the various practice components or intervention strategies. Some of these components/strategies include: assertiveness training, biofeedback, cognitive/coping, commands/limit setting, communication skills, crisis management, educational support, emotional processing, family engagement, family therapy, functional analysis, hypnosis, insight building, interpretation, mentoring, modeling, natural and logical consequences, parent coping, peer modeling, play therapy, problem solving, relationship/rapport building, relaxation, response cost, self-reward, social skills training, supportive listening, tangible rewards, time out, and twelve-step programming.

However, practice has not shifted significantly toward increased use of the practice components as has been intended. CAMHD contracts with approximately 48 agencies with over 500 clinicians. Although supervisors may attend training, not all clinicians are reached through training efforts. Despite evidence that clinicians are not adopting and using the practice components to the extent intended, measurement has produced better outcome data than in the past, leading to questions as to what factors are tied to improved outcomes. It has been suggested that engagement with clinicians may be a better predictor of good outcomes than use of the evidence-based practice components. Regardless, *Hawaii's* approach is not to be “wedded” to any particular evidence-based treatment, but rather to offer the practice components that comprise evidence-based treatments as options that providers can use to improve their practice approaches.

RFPs for providers emphasize the commitment to evidence-based practices. In addition, the state invests resources in practice development, including training, supervision, workshops, and the development of materials and tools to support the adoption of evidence-based practices (such as menus or “blue cards”, fact sheets, and curricula).

---

Various evidence-based practices are being added as services that will be covered under the state's Medicaid plan, including Multisystemic Therapy (MST), Functional Family Therapy, Parent Skills Training, and Multidimensional Treatment Foster Care. There is funding for the development, training, and fidelity monitoring of evidence-based practices. The state has "practice development specialists", who have provided training and technical assistance to supervisors and clinicians. The state has provided resources for start-up, training, supervision, and fidelity monitoring of MST and will be doing this for Multidimensional Treatment Foster Care and Functional Family Therapy.

The state has contracted for these evidence-based services. For example, CAMHD has contracted for eight MST teams statewide, and will be contracting for Functional Family Therapy statewide at all agencies. Multidimensional Treatment Foster Care will be started in two sites and outcomes will be examined. General fund dollars are used to support the training, start-up, supervision, fidelity monitoring and other expenses attendant to developing the capacity and delivering these interventions.

## **NE** Central Nebraska *Financing Specific Evidence-Based Practices*

Through cross-system collaboration and strategic financing at the state and regional level, **Central Nebraska** families now have access to Multisystemic Therapy (MST). Nebraska built MST into its application for a federal system of care grant. The state viewed MST as a therapeutic intervention with good outcomes for youth in the juvenile justice system. Federal grant funds were used for the development phase of MST, for clinical consultation, and to train two mental health centers to become MST providers. Nebraska "grew its own" MST, rather than inviting a MST provider to come into the state and set up shop. Although no one system is able to pay for all the costs of MST, by sharing the financing responsibilities, the provider is guaranteed to receive the full case rate amount. One mental health center continues to offer MST; the second center, located in a rural area, was not able to sustain the program. Approximately 226 youth and families participate in MST each year.

Nebraska's federal State Infrastructure Grant (SIG) has enabled the state to review evidence-based practices (EBPs) from a statewide perspective; to study the "real" costs for implementing EBPs, including development, training, monitoring, licensing; and to make decisions about how to proceed. There has been discussion of shifting funds from services that are not evidence-based to those that are, but this raises concern about limiting the types of services that are available and prescribing specific services, which is counter to Nebraska's philosophy of individualized and family-centered care. Through its SIG work, Nebraska is engaged in a comprehensive process to assess and select evidence-based practices that fit the unique character and needs of the state.

The wraparound approach is the basis for the work in Central Nebraska's system of care. To ensure fidelity to the wraparound model, Region 3 Behavioral Health Services (BHS) contracts with Families CARE to collect Wraparound Fidelity Index information from parents, youth and care coordinators. This feedback allows for continual improvements of the program and builds a capacity for parent-to-parent support by using a family evaluator. Other team members who participate on the child and family teams also are asked to assess wraparound fidelity on a semi-annual basis.



---

## **Choices** Choices

### ***Providing Technical Assistance on Implementation of Evidence-Based Practices***

The state mental health agency contracts with Choices to operate a Technical Assistance Center (TA Center) to provide training, coaching and technical assistance for more than 60% of *Indiana's* counties that are developing local systems of care. The state and the TA Center are now exploring mechanisms for identifying and disseminating effective models of care (i.e., evidence-based practices [EBPs]) and strategies for “building a culture” supportive of implementation. One barrier is that, aside from some resources for technical assistance, there are no extra resources for the capital expenditures that are required to become a provider of particular evidence-based practices, nor are there resources for ongoing training, support, and fidelity monitoring. Reimbursement mechanisms for EBPs also are needed, e.g., Medicaid billing codes. MST and Functional Family Therapy can be billed under the current Medicaid plan. The TA Center currently is assembling a group of stakeholders to explore what EBPs are being implemented in Indiana with fidelity and to assess gaps.

In addition, to assess fidelity to the wraparound approach that forms the basis for service delivery in systems of care, the TA Center is responsible through a subcontractor for completion of the Wraparound Fidelity Index (version 4) for a sample of more than 100 caregivers, care coordinators and youth in 2007.

## **AK** Bethel, Alaska

### ***Financing Specific Evidence-Based Practices***

Some state grant funding is available for evidence-based practices (e.g. Fetal Alcohol Syndrome, Youth Substance Abuse treatment). Training on evidence-based practices (EBPs), for example, is only offered if it is covered by a state grant. In addition, Medicaid incentivizes the use of EBPs through the identification of covered services that can be used for various EBPs.

*Alaska's* Department of Juvenile Justice (DJJ) strongly supports implementation of EBPs including Multisystemic Therapy (MST) and Aggression Replacement Therapy. DJJ also uses Youth Level of Services (YLS), a required intake form which collects criminal history, mental health needs, and family history. There is a strong focus on family strengths and efforts to get the family involved. DJJ is also participating in an Office of Juvenile Justice and Delinquency Prevention-funded project on performance based standards for juvenile facilities.



---

## D. Promote and Support Early Childhood Mental Health Services

### **Strategies include:**

- Maximizing Part C and Child Find financing
- Financing a broad array of services and supports for young children and their families
- Using multiple sources of financing for early childhood mental health services
- Financing early childhood mental health consultation to natural settings
- Financing services to families of young children

### ► **Maximize Part C and Child Find Financing**

In **Arizona**, the behavioral health system has collaborated with Part C to develop workshops in early childhood mental health, to create an assessment tool for the 0–5 population and accompanying training for providers, and to build provider capacity for working with young children. **Vermont’s** Child Find system, with responsibility given to the Department of Education, is charged with identifying and evaluating young children who are eligible for services under Part C. Collaboration between the mental health and education systems specifies roles and responsibilities related to Part C of IDEA and responsibility for providing and financing early childhood mental health services.

### **AZ** **Arizona**

#### **Using Part C Funds**

In **Arizona**, there has been increasing recognition of early childhood mental health issues by the mental health system. For example, the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/BHS) gave the Part C program funds to develop a seven-part series of workshops on early childhood mental health; most of those who attended, however, were providers in the Part C network, not the Regional Behavioral Health Authorities (RBHAs).

ADHS/BHS now requires RBHAs to use a 0–5 assessment tool. In late 2005, ADHS/BHS contracted with a provider that specializes in the 0–5 population to help develop the 0–5 assessment tool and train providers on its use. ADHS/BHS is using federal Child and Adolescent System Infrastructure (CA-SIG) grant dollars to support this effort. One impetus behind use of the tool was the changes in the Child Abuse Prevention and Treatment Act, requiring referral of young children involved with child protective services (CPS) to Part C. The 0–5 assessment tool was developed by families, providers, Part C and other stakeholders. RBHAs are required to screen CPS-involved children, 0–5, within 24 hours and then refer to Part C if appropriate. Part C stakeholders indicated that, initially, only 18% of referrals met Part C eligibility criteria so a developmental screen was added; now children are referred if there is a developmental issue involved. ADHS/BHS also added a new contractual requirement in RBHA contracts, requiring RBHAs to hire 0–5 specialists, (which Value Options indicated it had some trouble finding). The state is using federal SIG grant dollars to support a competency roll-out for the 0–5 population, using the Harris Training Center in-service model of three-tiers of competency, covering paraprofessionals through credentialed specialists.

---

At the time of the site visit, Part C and ADHS/BHS were involved in further discussions about how to improve coordination and capacity for the 0–5 population. A few providers are in both Part C and RBHA networks and, reportedly, are overtaxed because of high need and insufficient capacity. Value Options (VO) in Maricopa County has taken the leadership in putting together a group of Part C, provider, child welfare, family and other stakeholders to develop a training program for building more capacity, but this is in the early development stage. VO also was concerned about getting the adult system involved, particularly to coordinate services for adults with substance abuse problems who have young children. Also, the Governor’s Office on Children, Youth and Families is trying to develop an infant mental health plan that could be endorsed by all agencies. Part C has an interagency early intervention team, on which ADHS/BHS sits. In the past, Part C and ADHS/BHS worked together to develop an early childhood SAMHSA grant application, but it was not funded.

## **VT** Vermont

### ***Using Part C Funds***

In **Vermont**, the Early Intervention Program under Part C, is known as the Family Infant and Toddler Program. Vermont has a comprehensive Child Find system including policies and procedures that ensure all infants and toddlers who may be eligible for services under Part C are identified and evaluated. (An eligible child is a child from birth to three years of age who is at risk for and/or who experiences measurable developmental delays and/or has a diagnosed physical or mental condition that is likely to result in developmental delay.) State education policy gives the local education agencies Child Find responsibility for children birth to age three. The Department of Education has ultimate responsibility for ensuring that a comprehensive Child Find system exists in Vermont. The Agency for Human Services (AHS), the umbrella agency that houses the Department of Mental Health, has specific supporting roles and responsibilities, including administration of funds. Child Find is funded under Part B so that “each non-educational public agency, including state Medicaid, precedes the financial responsibility of the local education agency.” Part C funds are utilized as payer of last resort for the services covered.

AHS and the Department of Education, the co-lead agencies for efforts under Part C, have a formal agreement (July 2006) that specifies roles and responsibilities. AHS specifically funds coordination and early intervention services, consistent with federal rules governing expenditure of Part C dollars (requiring non-supplantation, state maintenance of effort, and payer of last resort).

---

## ► Finance a Broad Array of Services and Supports for Young Children and their Families

Both **Arizona** and **Vermont** finance a broad array of services and supports for young children and their families.

### **AZ** Arizona

#### ***Financing a Broad Array of Early Childhood Mental Health Services and Supports***

The **Arizona** Department of Human Services/Behavioral Health Services (ADHS/BHS) conducted a cross-walk of DC 0–3 and ICD 9-CM services with Medicaid-covered services to provide guidance to providers on how to bill Medicaid for 0–3 services. (See: <http://www.azdhs.gov/bhs/provider/icd.pdf>) Many covered services can be provided in natural settings. The system can cover mental health consultation services to child care, Head Start, etc. even if the child is not present as long as the consultation pertains to an identified child. The system also can provide consultation to families even when the child is not present, again, as long as the consultation pertains to the identified child. The system also covers family education and support services.

### **VT** Vermont

#### ***Financing a Broad Array of Early Childhood Mental Health Services and Supports***

As part of its case for enhancing early childhood mental health services, **Vermont** estimates that approximately 10–15 percent of all typically developing preschool children have chronic mild to moderate levels of behavior problems, with much higher prevalence rates in the population of children who are poor. The state also has documented the difficult developmental path children and their families face without intervention and support and the costly consequences of failure to act. The problems impact many aspects of the lives of the children, their families and the communities in which they live. The early childhood mental health (ECMH) system is viewed as more than a mental health system of care. It has expanded direct treatment and consultation, encompassing prevention, early intervention and treatment services. It is designed to:

- Incorporate mental health in early childhood natural settings —“where kids are”
- Use a three-pronged public health model: promotion for healthy social-emotional development of all children and families; prevention that focuses supports for children and families considered at-risk; and intervention to serve children with diagnosed problems.
- Acknowledge and approach the work as a partnership engaging and involving families, caregivers, early childhood providers, mental health providers, and the community.

---

ECMH promotion efforts include dissemination of information on healthy social-emotional development, provision of developmental screening and high-quality child care, and the use of an evidence-based curriculum. Prevention includes home visiting, mental health consultation, family mentors, using curricula that fosters social skills, and family and caregiver supports. Intervention services include on-site mental health consultation (child or family-centered, or program/agency focus), crisis teams, wraparound services, relationship-based therapy, hot line for families, behaviorally-based programs, and in-home treatment.

Vermont received a federal children's services mental health grant in 1997 (\$5.7 million over 5 years) to create the Children's UPstream Services project (CUPS), a comprehensive early childhood mental health initiative. The CUPS program was designed to expand community-based mental health services for young children experiencing a severe emotional disturbance and their families, and strengthen local interagency coordination to increase the number of children who enter kindergarten with the emotional and social skills necessary to be active learners in schools. The initiative served as the foundation for the development of a strategic approach to maximizing the impact of federal grant dollars with utilization of Medicaid and EPSDT funds, as well as state match funds. Services supported through CUPS include:

- Intervention services including crisis outreach, case management, intensive home-based services, respite care
- Consultation for child care and other direct service providers
- Cross-agency training
- Parent peer support
- Information and referral

A number of other programs also are considered part of the ECMH array: The Family, Infant and Toddler Program (FITP) which provides a family-centered, coordinated system of early intervention services for infants and toddlers with developmental delays and disabilities and their families. This program provides access through a single, integrated, individualized family service plan. The Healthy Babies program helps Medicaid-eligible pregnant women and families with young children connect with high quality health care and support services in the community. Vermont has employed the Success by Six umbrella to encompass these and other initiatives designed to ensure that children are ready for primary school.

---

## ► Use Multiple Sources of Financing for Early Childhood Mental Health Services

### **Strategies include**

- Financing behavioral health screening of high-risk populations and linkages to services as needed
- Incorporating behavioral health screening in EPSDT-funded screens
- Financing early intervention services for at-risk populations
- Incorporating financing and incentives for linkages with and training of primary care practitioners

Multiple sources of funding are utilized to finance early childhood mental health services in **Arizona** and **Vermont**, including Medicaid, general revenue, Part C of IDEA, Head Start, and a variety of other federal, state, and local funding streams.

### **AZ** Arizona and **VT** Vermont

#### ***Using Multiple Funding Streams for Early Childhood Mental Health Services***

- In **Arizona**, sources of financing for early childhood behavioral health services and supports include: Medicaid, state general revenue, Part C, child welfare, education (State School for the Deaf and Blind), mental retardation/developmental disabilities, general revenue, Medicaid Developmental Disabilities waiver, Head Start, and some local school district funding.
- In **Vermont**, federal, state, and private funding contribute to financing for early childhood mental health services. These resources include: IDEA, Part B and Part C, Medicaid (including EPSDT and waiver options), S-CHIP, SAMHSA block grant and special initiative funding, MCH (Title V) and HRSA funding, Head Start, Child Care Development Fund, TANF funding, private sector grants, private insurance, and family contributions.

---

## ► Finance Early Childhood Mental Health Consultation to Natural Settings

Mental health consultation to early childhood settings (such as day care centers, Head Start, preschools, pediatricians' offices, etc.) is an important component of the array of early childhood mental health services and supports. **Arizona** and **Vermont** finance early childhood mental health consultation using Medicaid dollars in Arizona and mental health general revenue funds in Vermont.

### **AZ** Arizona and **VT** Vermont

#### **Financing Early Childhood Mental Health Consultation**

- In **Arizona**, the system can cover mental health consultation services, using Medicaid dollars, to child care, Head Start, etc. as long as the services pertain to an identified child (the child does not have to be present). Part C stakeholders indicated that Early Head Start and Head Start programs have their own mental health staff with whom they contract or hire directly (i.e., not through Regional Behavioral Health Authorities [RBHAs]). They also indicated that there is some discussion occurring at the Governor's Office on Children, Youth and Families about expanding mental health capacity for consultation to child care settings. In Maricopa, Value Options used prevention dollars to contract with a provider to implement the "Incredible Years" in child care centers.
- In **Vermont**, consultation is covered both to families and other professionals in a variety of "natural settings." Besides in-home mental health services, consultations take place in child care centers, parent-child centers, preschools, Head Start, pediatricians' offices, and others. Early childhood mental health consultation is financed by mental health general revenue dollars.

## ► Finance Services to Families of Young Children

**Arizona** and **Vermont** both finance services to families of young children, without the requirement of the child being present. These services are reimbursable as long as the services relate to the child's behavioral health needs and are outlined in the individualized service plan.

### **AZ** Arizona and **VT** Vermont

#### **Financing Services to Families of Young Children**

- In **Arizona**, the managed care system can provide services to the family when the child is not present as long as the services relate to the child's behavioral health issues and needs.
- In **Vermont**, many different services to families of young children are financed, including home visiting and other parenting services, family support, respite care and financing to support and engage parents as part of decision-making teams. The child does not need to be present, but the services must relate to the issues/problems outlined on the service plan.

---

## E. Promote and Support Early Identification and Intervention

### ► Finance Behavioral Health Screening of Children and Youth at Risk and Linkages to Services as Needed

Strategies for screening children and youth at high risk for behavioral health problems and linking youth to needed services were found in the sites. Typically, sites screen youth entering the child welfare or juvenile justice systems and make appropriate referrals for further evaluation or for services as indicated.

#### **AZ** Arizona

##### ***Screening Child Welfare and Juvenile Justice Populations***

In response to the Child Abuse Prevention and Treatment Act (CAPTA), **Arizona** Department of Health Services, Division of Behavioral Health Services (ADHS/BHS), the Part C program and child welfare worked out a system for rapid referral of children under age three, who come to the attention of Child Protective Services (CPS), to receive a developmental assessment through the managed care system within 24 hours and referral to the Part C program if a developmental issue is found. In addition, child welfare and ADHS/BHS have developed an urgent response system with referral to the managed care system within 24 hours when a child of any age comes into contact with CPS and is removed from home. ADHS/BHS took the lead in developing a Practice Improvement Protocol focused on serving children and families involved in child welfare, which also describes the urgent response system requirements. (See [http://azdhs.gov/guidance/unique\\_cps.pdf](http://azdhs.gov/guidance/unique_cps.pdf).)

The juvenile justice system in Maricopa County has recently implemented use of the MAYSI-2 (Massachusetts Youth Screening Instrument, Version 2) to identify high risk youth coming into detention; all detained youth are administered the MAYSI-2 within 48 hours of coming into detention. The juvenile justice system uses its own staff (and dollars) to administer the screening. An issue in serving youth in detention is that Comprehensive Service Providers in the Regional Behavioral Health Authority (RBHA) network cannot always bill Medicaid for services provided on site at detention, depending on the youth's legal status, even if the youth is eligible for Medicaid. ADHS/BHS has issued a technical assistance document specific to youth in detention settings to clarify and maximize ability to utilize Medicaid for this population to the extent possible. (See: [http://www.azdhs.gov/bhs/provider/sec.5\\_1pdf](http://www.azdhs.gov/bhs/provider/sec.5_1pdf).)



---

## **HI** Hawaii

### ***Screening the Child Welfare Population***

A multidisciplinary team (MDT) is contracted by the child welfare system to assess children to determine if a mental health assessment (psychological or psychiatric evaluation) is needed. The Child and Adolescent Mental Health Division (CAMHD) has recently entered into a memorandum of understanding (MOA) with child welfare to give them additional funds to support expanding their contract as a means of increasing access to care.

## **NJ** New Jersey

### ***Using Common Screening and Assessment Tools Across Agencies***

The state utilizes common screening and assessment tools that are used across various systems and agencies that serve children. The tools are used at the point of access into the various systems, to screen and evaluate children for risk and mental health treatment needs. The CANS (Child and Adolescent Needs and Strengths) tool is a standardized assessment instrument that incorporates a quantitative rating system within an individualized assessment process. Versions of the CANS are used for initial screening and assessment, for crisis assessment, and for use by Care Management Organizations to guide service planning for youth with the most intensive service needs. The state mandates that the Crisis Assessment Tool (CAT) be used by the state's mobile response and stabilization providers. The Needs Assessment tool is mandated for use by the Contracted Systems Administrator and system partners (such as child welfare workers and providers) at entry to screen for level of intensity of service need. The Comprehensive Strengths and Needs Assessment tool is mandated for use by Care Management Organizations, youth case management providers, and by residential treatment providers for individualized service planning. The tools are part of the state's Information Management and Decision Support (IMDS) system.

## **VT** Vermont

### ***Screening the Child Welfare and Juvenile Justice Populations***

**Vermont** supports screening for every child coming into child welfare or juvenile justice custody. The Department for Children and Families (DCF) has taken the responsibility for creating a screening process for children entering custody. As part of the screening process, DCF contracts with various agencies throughout the state for the following activities: gather existing medical, educational, and psychological information on new entrants into custody; meet with youth, families and treatment teams to gather the family's history; and utilize several screening tools to identify concerns and to assist with care planning. The goal is that this process will be completed within 30 days of assignment to a screener. The DCF screening may be done in conjunction with additional expert assessments of specific issues. Screening tools used are based on the age and known background of the child and may include: Child Behavior Checklist (CBCL), Massachusetts Youth Screening Instrument (MAYSI), geno-grams, eco-maps, and the Ansell-Casey Life Skills Assessment. Medicaid finances the screening and assessment.

---

## **NE** Central Nebraska *Screening the Juvenile Justice Population*

Medicaid currently is leading efforts in **Nebraska** (statewide) to provide a Comprehensive Child and Adolescent Assessment (CCAA) for youth who enter the juvenile justice system. Medicaid has contracted with a number of providers to conduct clinical evaluations of mental health/substance abuse treatment needs before youth are committed. Although a number of assessment tools have been identified for these evaluations, the clinicians are not required to use a specific one. Instead, they are asked to select the most appropriate tool(s) for each youth. Their assessments and recommendations focus on clinical issues and the level of care that may be needed for each youth. Medicaid pays \$1,500 for each of these comprehensive evaluations. Authorization of the services that are recommended rests with Magellan (the statewide behavioral health managed care entity).

### ► **Incorporate Behavioral Health Screening in EPSDT-Funded Screens**

In **Vermont**, EPSDT screens, paid for by Medicaid, incorporate behavioral health screening components. No specific instruments are required. Also in Vermont, mental health professionals are co-located in pediatric settings to improve access to behavioral health assessment and intervention.

## **VT** Vermont *Incorporating Behavioral Health Screening in EPSDT Screens*

EPSDT, administered through the Department of Health, provides comprehensive assessments for young children and has played a key role in growing early childhood mental health services in the state. Trained health and mental health care personnel conduct EPSDT screens, including appropriate behavioral health screens in an increasing variety of locations, including in schools under contract with some districts. **Vermont's** efforts recognize the need for appropriate screening tools and interventions. The state does not prescribe a single tool but rather provides a menu of state-approved tools. Several screening tools and guidelines are available, including the Pediatric Symptom Checklist and the Child Behavior Checklist, along with references for additional resources.

Opportunities for identification of behavioral health problems and referral for treatment also are provided in the pediatric collaborative efforts that the state has undertaken. The model co-locates a community mental health professional jointly trained in mental health and substance abuse in a pediatric or family practice office to screen, refer as appropriate, and coordinate mental health and substance abuse treatment, provide short-term intervention, and provide staff consultation. This model augments the primary care practice, provides assessment and intervention resources, creates a smooth connection for families, helps train professionals in the field, and increases community awareness about the importance of addressing mental health. About 15 mental health professionals are working to improve screening and services in primary care and private agency settings across the state. Medicaid finances the EPSDT screens.

---

## ► Finance Early Intervention Services for Children and Youth at Risk

Financing strategies to provide early intervention services for children at-risk were found in *Hawaii*, *Vermont*, *Central Nebraska*, and *Wraparound Milwaukee*.

### **HI** Hawaii

#### ***Providing Behavioral Health Services to At-Risk Children in Schools***

The Department of Education (DOE) provides a “Comprehensive Student Support System” that offers a range of short-term behavioral health services with the goal of early identification and intervention with students before they may become eligible for special education services through an individual education plan (IEP). Following the identification of a need (through consultation with teachers) and initiation of services, the team reconvenes to decide if a more formal evaluation is needed to determine if there is a disability which requires more intensive or longer-term services.

Beginning with fiscal year 2000–2001, DOE also took responsibility for serving students with less severe emotional and/or behavioral challenges through newly established school-based behavioral health services. Youth needing less intensive mental health services, such as outpatient counseling, now receive these services through school-based mental health (SBBH) services. The coordinated relationship between the education and mental health systems provides a system of care with the school as the central access point for mental health services for youth with educational disabilities. Medicaid health plans also provide assessment and basic levels of outpatient treatment, which can be considered early intervention. More intensive services, if needed for the Medicaid eligible youth, are obtained through the Child and Adolescent Mental Health Division (CAMHD) children’s mental health system.

### **VT** Vermont

#### ***Providing Services to High-Risk Families***

Financing for screening, assessment and a range of services is available for children and their families with identified problems, as well as those at risk. There are efforts through *Vermont’s* system of care to identify high-risk families. For example, the CUPS early childhood initiative has focused on identifying high-risk families with young children including teen parents, families affected by substance abuse, families in crisis, families with children exposed to domestic violence, and others. Linkages with the child welfare agency (Department for Children and Families) and the state’s domestic violence network have both been used to focus attention on high-risk families and identify those in need of intervention. Each local education agency (LEA) is responsible for operating a Student Support System that identifies and intervenes with students before they require special education services, including youth with behavioral health issues. Referral may be made to a local mental health Designated Agency (DA) or services may be provided at the school under a contract with the DA. Almost half of all public mental health services to Medicaid eligible children and adolescents in Vermont are provided in conjunction with a school — a major benefit in a rural state with little public transportation.

---

## **NE** Central Nebraska

### ***Providing Wraparound Approach to At-Risk Children and Families***

The mission of the Early Intensive Care Coordination Program (EICC) is to use the wraparound approach and family-centered practice to coordinate services and supports for families involved with the child welfare system whose children are at risk of becoming wards of the state. The EICC is a voluntary program intended to prevent children from being removed from their homes or going into higher levels of care (if not needed). The EICC also addresses parental mental health, substance abuse, and developmental issues. There is concern about sustained funding for EICC at the current case rate. In fiscal year 2005, \$355,780 was invested in EICC; however, the Integrated Care Coordination (ICCU) program cost savings for fiscal year 2005 was only \$66,608. Therefore, Region 3 Behavioral Health Services (BHS) had to draw upon its previously accumulated savings to fully fund EICC in fiscal year 2005. (Note: Since the site visit, **Central Nebraska** has been unable to continue its EICC Program due to state policy changes limiting the use of funds to children who are current wards of the state. In place of EICC, a new School-Based Intervention Program is being implemented for children and youth in custody.)

## **Wraparound Milwaukee** **Wraparound Milwaukee**

### ***Providing Wraparound Approach at an Earlier Stage***

Wisconsin has a new Comprehensive Community Services Medicaid benefit that covers more community-based interventions than outpatient and that allows for cost reimbursement up to a certain level of cost per day; the provider has to show the actual cost of care, so it is rather labor-intensive. The counties co-finance the benefit by putting up 40% of the match. **Wraparound Milwaukee** is looking at use of this new benefit to implement a “Wrap Light” that would provide less intensive services than Wraparound Milwaukee but at an earlier stage. It is considering the possibility of using child welfare and juvenile justice dollars to cover the match; for example, the juvenile justice system has access to county levy money (which mental health does not) and could use these types of dollars as match.

---

## ▶ Incorporate Financing/Incentives for Linkages with and Training of Primary Care Practitioners

*Vermont, Choices, and Wraparound Milwaukee* incorporate financing for linkages with primary care practitioners.

### **VT** Vermont

#### ***Implementing a Pediatric Collaborative Approach***

**Vermont** has been piloting a pediatric collaborative approach for the past five years, and it has been an effective model for provision of preventive care, early screening, early intervention, and service coordination for children and their families at risk for mental illness and/or substance abuse disorders. The primary care office seems to be a less stigmatizing environment where parents and children are more likely to address many health concerns, including issues of social and emotional health. The model co-locates a community mental health professional jointly trained in mental health and substance abuse in a pediatric or family practice office to screen, coordinate mental health and substance abuse treatment, provide short-term intervention, and provide staff consultation. The state does not mandate any special instrumentation for behavioral health screens but has an approved list of tools. In addition, the primary care office will have regular consultation with a child psychiatrist for two hours a week. Finally, the model provides immediate access to more intensive mental health and substance abuse treatment when necessary and allows early interventions which result in the reduction of mental health and substance abuse related issues. More than a dozen mental health professionals are working to improve screening and services in primary care and private agency settings across the state, and there is great interest in expanding the effort and increasing the number of practices and practitioners involved. Medicaid funds services using this approach.

### **Choices** Choices

#### ***Addressing Health/Medical Domain***

One of the life domains addressed in service plans is “health/medical.” As such, it is seen as the responsibility of **Choices** to see that every child has a medical home and that medical, dental, and eye care needs are addressed. If the child and family do not have private insurance or Medicaid, than flexible funds are used to pay for health services. Care coordinators assist the family to determine if they are eligible for private or public health insurance; flexible funds also can be used to cover co-payments, prescriptions, or emergency room visits.

### **Wraparound Milwaukee** Wraparound Milwaukee

#### ***Conducting Reviews with Primary Care Practitioners***

**Wraparound Milwaukee** conducts weekly reviews with primary care practitioners at the city’s Federally Qualified Health Center (FQHC), where most of its population goes for primary care. It also is considering developing a walk-in psychiatric clinic at the FQHC.

---

## F. Support Cross-Agency Service Coordination and Dedicated Care Coordinators

**Strategies include:**

- Financing cross-agency service coordination at the service delivery level
- Financing dedicated care coordinators

### ► Finance Cross-Agency Service/Care Coordination at the Service Delivery Level

Cross-agency service coordination at the service delivery level is financed by the sites, typically by financing dedicated care managers through various mechanisms.

#### **HI** Hawaii

##### ***Using State- Employed Mental Health Care Coordinators***

Mental health care coordinators (MHCCs) are state employees of the Child and Adolescent Mental Health Division (CAMHD), placed in each of the Family Guidance Centers. These care coordinators are responsible for the individualized service planning process, involving the convening of child and family teams to develop and implement a Coordinated Service Plan (CSP). The care coordinators are responsible for authorizing and coordinating the services specified in the plan across providers and agencies. A key function of the care coordinators is to develop collaborative working relationships with other child serving agencies. The specific responsibilities of the MHCCs include the following:

- Ensuring a sound clinical assessment is conducted
- Convening team meetings to conduct strength-based planning via the CSP process
- Developing the written CSP and obtaining agreement and signatures of all participants
- Implementing the CSP, including linkages to other services and programs, referrals to natural community supports, advocacy, and coordination with agencies and individuals
- Performing ongoing monitoring and evaluation of the effectiveness of the CSP and services
- Revising/adapting the plan as needs change through team participation
- Ensuring that system of care principles always guide planning for all services

To fulfill their duties, MHCCs are trained in: engagement skills, intensive case management, the CSP process, mental health assessments, CAMHD outcome measures (CAFAS, CALOCUS, Achenbach Child Behavior Checklist), and evidence-based services/best practices.

---

## **NJ** New Jersey

### ***Using Care Management Organizations with Care Managers***

Cross-agency care management is provided through **New Jersey's** Care Management Organizations (CMOs), which are non profit organizations specifically created to perform this function. The CMOs are funded through performance-based contracts with the New Jersey Department of Children and Families. CMOs are designed to serve the needs of children with the most serious behavioral health challenges and their families and function as a community-based alternative to more restrictive out-of-home services. To enable care managers to provide intensive care management, caseloads are capped at a ratio of one care manager to ten children.

## **VT** Vermont

### ***Using Designated Agencies with Care Managers***

State law and policy fix the responsibility for system of care management. The Designated Agency is the locus of accountability for planning and implementing services and for care management for children with intensive mental health needs. The local agency that has lead responsibility for ensuring that the Coordinated Service Plan, developed by an individual treatment team, is in place can vary depending on the needs of the child and family. If the child is in the custody of the Department for Children and Families, then that department takes the lead. If the issues occur primarily in the educational setting and the child is not in state custody, then the local school district is responsible. In all other cases, the designated community mental health agency is responsible for developing the Coordinated Services Plan that outlines goals and for ensuring that the plan is implemented and modified as appropriate. Whichever agency takes the lead, an agency case manager has the principal role in activating the coordinated service plan process. The system of care supports dedicated care/ case managers for the approximately 200 children in the system who require high-end services. If problems or issues arise that the individual treatment team cannot resolve in case planning or service implementation, the team or any member may initiate a referral to the Local Interagency Team (LIT) in the region for help. Case management financing comes largely from Medicaid, but may vary depending on the lead agency and scope of activities.



---

## **NE** Central Nebraska *Using Care Coordination Programs*

The service system in **Central Nebraska** is built on a belief in cross-agency coordination, one care coordinator per family, and partnering with families. This philosophy is reinforced by funding several care coordination programs. The Professional Partners Program (PPP), the Integrated Care Coordination Units (ICCU), the Early Intensive Care Coordination Program (EICC), the School Wraparound Program, and the Care Management Team all offer care coordination to certain targeted populations of children and families. A case rate methodology funds the care coordinators in the PPP and the ICCU. The Central Service Area of the Dept. of Health and Human Services (child welfare) and Region 3 Behavioral Health Services (BHS) share the cost of the care coordinators in ICCU and EICC and co-fund the Care Management Team. Region 3 BHS and the school system share the costs of employing the facilitators in the School Wraparound Program. Reaching agreement on the care plan often requires negotiation, e.g., if the care plan calls for specific Medicaid-funded services, first the child and family team must agree upon recommended services and then the clinician from the team negotiates with a liaison at Magellan. (Note: Since the site visit, Central Nebraska has been unable to continue its EICC Program due to state policy changes limiting the use of funds to children who are current wards of the state. In place of EICC, a new School-Based Intervention Program is being implemented for children in custody.)

## **Choices** Choices *Using Care Coordinators*

Each child and family served by **Choices** is assigned to a care coordinator who works with the family to form a child and family team. Each care coordinator belongs to a team, typically comprised of a supervisor, five care coordinators, and one to three case managers. In Indiana, the teams are physically located at Dawn, and most of their training and supervision occurs at Dawn, but they are actually employed by the four community mental health centers to enable them to bill Medicaid through the Rehabilitation Option for the care management services provided to eligible children. Care coordinators are employed by Choices in Ohio and Maryland. Each care coordinator carries a caseload of about eight to ten children; case managers are considered “care coordinators-in-training” and play a supportive role. The responsibilities of the care coordinator are extensive and involve: organizing and convening a child and family team, facilitating a strength-based discovery/assessment process, developing an individualized care coordination plan with the team, assisting teams in finding the services and supports necessary to address care plan goals, authorizing services monthly for the upcoming month, monitoring and evaluating service provision and outcome attainment, coordinating service delivery among all involved providers and the family, writing all required reports, providing information to referring workers and other team members, and serving as an educator and facilitator for the family and the various systems. The approach used by the care coordinators is referred to as “participatory care management.” Developed by Choices, the approach uniquely blends the concepts of both managed care and systems of care by integrating the system of care philosophy and its core values (e.g., family involvement, individualized/wraparound approach, coordinated care) with managed care technologies for clinical and fiscal management (e.g., case rates, outcome, focus).

---

## **Wraparound Milwaukee** **Wraparound Milwaukee**

### ***Using Care Coordinators***

Child and family teams address issues across systems at the service delivery level, and their functions are financed through ***Wraparound Milwaukee***. Additionally, the system contracts with care coordinators who work with small numbers of children and their families (1:8) and are responsible for outcomes across systems. Care coordinators are financed through Wraparound Milwaukee's blended funding pool.

---

## IV. Financing to Support Family and Youth Partnerships

A central tenet of the systems of care philosophy is that families and youth are full partners in all aspects of the planning and delivery of services. The concept of family and youth involvement has been strengthened over time, and the new concept of *family-driven, youth-guided* care is achieving broad acceptance. Family-driven care means that families have a primary decision making role in the care of their own children, as well as in the policies and procedures governing care for all children in their community, state, tribe, and nation. Similarly, youth-guided care means that young people have the right to be empowered, educated, and given a decision making role in their own care and in the policies and procedures governing care for all youth in their community, state, tribe, and nation. Financing strategies are needed to support partnerships with families and youth at the service delivery level in planning and delivering their own care and at the system level in designing, implementing, and evaluating systems of care. In addition, partnering with families and youth requires financing for services and supports not only for the identified child, but also for family members to support them in their caregiving role. Financing to fund program and staff roles for family members and youth also reflects a system of care that is committed to partnerships, as does financing for family- and youth-run organizations.

### Financing Strategies Include:

- A. Support Family and Youth Involvement and Choice in Service Planning and Delivery**
- B. Finance Family and Youth Involvement in Policy Making**
- C. Finance Services and Supports for Families and Other Caregivers**

## A. Support Family and Youth Involvement and Choice in Service Planning and Delivery

### **Strategies include:**

- Financing supports for families and youth to participate in service planning meetings
- Financing family and youth peer advocates
- Incorporating financing to provide families and youth with choices of services and/or providers
- Incorporating financing to train providers on how to partner with families and youth

### ► Finance Supports for Families and Youth to Participate in Service Planning Meetings

The sites studied incorporate financing to support family and youth participation in service planning meetings. They typically pay for such supports as transportation, child care, food, and interpretation on an as-needed basis.

**AZ** Arizona, **HI** Hawaii, **VT** Vermont,

**NE** Central Nebraska, **Choices** Choices, and

**Wraparound Milwaukee** Wraparound Milwaukee

### ***Financing Transportation, Child Care, Food, and Interpretation to Support Family/Youth Participation in Service Planning Meetings***

- In **Arizona**, family and youth participation on child and family teams is one of the core principles of the system. The managed care system pays for child care, transportation, food, and interpreters as needed.
- In **Hawaii**, child care may be provided if the family member has to fly to another island to participate in a child and family team meeting. In some instances, a child may be served on another island, for example, if a child needs to be in a different environment or requires hospitalization, which is available only on Oahu. Transportation and food are funded out of ancillary funds. Parent partners can advise families as to the availability of these resources and can help families to obtain them from the Family Guidance Centers when necessary. In addition, Hawaii Families As Allies (HFAA) provides some training for families on how to participate in service planning (such as training in advocacy, communication, how to speak up, how to become informed about what services are available, etc.)

- In **Vermont**, the participation of parents/family members on child and family teams is fundamental to system of care assessment, service planning and plan implementation. The local team determines the appropriate funding resources for supports, such as child care, interpreter services and/or transportation, that permit and facilitate family participation (and without which the parent/family member might not be able to participate). The funding resources depend on the supports required (e.g., interpreter services would be covered by Medicaid; others by state mental health, other partner agency funding, or available flexible funds.)
- **Choices** attempts to remove all potential barriers to the participation of family members at team meetings, such as transportation, child care, and conflicts with work, to facilitate and maximize their involvement. Depending on a family's needs, payments can be provided for bus passes, reimbursement for gas, and child care — even providing checks for child care in advance of the meeting. If necessary, arrangements can be made for someone at Choices offices to provide child care during child and family team meetings. Staff is empowered to do whatever is needed to remove barriers to participation. Flexible funds are used to cover costs such as these.
- In **Wraparound Milwaukee**, family and youth participation on child and family teams is a core principle. The system pays for child care, transportation, food, and interpreters to ensure that families can participate, using dollars from its blended funds pool.

## ► Finance Family and Youth Peer Advocates

Most of the sites provide financing for family and/or youth peer advocates. The role of these peer advocates typically includes working with families and youth to support them through the service planning and delivery process and providing a variety of types of direct assistance.

### **AZ** Arizona

#### ***Requiring Core Service Agencies to Hire Family Support Partners and Covering Family and Youth Peer Support Under Medicaid***

All Comprehensive Service Providers (core service agencies) are required to hire Family Support Partners (FSPs). In Maricopa County, FSPs are recruited, trained, and coached by the Family Involvement Center, though they are employed by the Comprehensive Service Providers. This arrangement enables FSPs to feel part of and supported by a larger family movement. The managed care system also covers family and youth peer support, which is a Medicaid-covered service. A new type of Medicaid provider which the state created, called Community Service Agencies (CSA), employs, trains, and supervises family and youth peer support providers. CSAs are agencies that do not have to be licensed as behavioral health clinics. For example, the Family Involvement Center in Maricopa County is a CSA and provides family-to-family and youth-to-youth peer support directly and bills Value Options for the service.

Also, **Arizona** Department of Health Services, Division of Behavioral Health Services (ADHS/BHS) is working with other child-serving systems to encourage them to fund family-to-family delivered peer support within their own systems and was making some headway with the juvenile justice system at the time of the study.

## **HI** Hawaii

### ***Financing Parent Partners***

Financing is provided for parent partners who serve as peer advocates and provide assistance and support to other family members. Parent partners are employees of **Hawaii** Families As Allies (HFAA) whose role involves supporting parents in advocating for their children and themselves. Parent partners attend meetings such as individual education plan (IEP) meetings and court proceedings with families, conduct workshops and support groups for families, and support families in a variety of other ways. Typically, parent partners work out of their homes, but they are tied to the various Family Guidance Centers, and they serve on Family Guidance Center committees and management teams, representing the interests of and advocating for families. Care coordinators provide a packet of materials about the availability of parent partners and about HFAA to family members receiving services. In addition, Family Guidance Centers make referrals to the parent partners for support. The registration process at Family Guidance Centers was modified to include a review by parent partners and to obtain consent for the parent partner to contact the family to provide support. New work currently is being undertaken to develop youth mentors to provide positive role models to other youth in areas including social and life skills. Some mentors will receive stipends from the new federal system of care grant in Hawaii. Curriculum development to provide training for this role is underway. A new RFP requires provider agencies to have a Family Specialist and a Youth Specialist. These roles can be assigned to direct service staff, but must be at least half-time positions.

## **NJ** New Jersey

### ***Financing Family Support Organizations with Family Support Coordinators***

The state funds Family Support Organizations (FSOs) in each region, which provide advocacy, support and education at the system and service delivery levels. They are funded with a combination of state general revenue, Medicaid administrative case management dollars, and federal discretionary grants. FSOs are required to fund Family Support Coordinators to work closely with families served by Care Management Organizations (CMOs), providing peer support and advocacy. The Family Support Coordinators are individuals with children involved in the system or who have been diagnosed with emotional problems and are available for families who request their help. A primary focus is to support the family's involvement in the individualized service planning process to ensure that the plan is supportive of their concerns, values, and preferences.

**VT Vermont**

***Financing Peer Support***

The **Vermont** Federation of Families for Children’s Mental Health provides the most extensive family organizational support for the system of care. It is the designated organizational representative in state law and policy and provides an array of services and supports (e.g., peer navigation, parent and provider training, information, and referral to resources).

Peer Navigator efforts, initially developed through a statewide collaboration with family organizations (financed through a federal grant from the Administration on Developmental Disabilities and the Administration on Children and Families), offers service participants the support of someone who has experienced the system first-hand. Peer Navigators assist individuals and families with accessing and navigating the health, education and human service systems. System of care principles and practice have brought these systems together to work in an integrated fashion to reduce crises and improve child and family health, mental health and well-being. Peer navigation is supported by agency grant and contract funds.

**NE Central Nebraska**

***Financing Family Partners***

To further support families in the formalized service system, a Family Partner, employed by Families CARE, provides support for each family served through the wraparound process in **Central Nebraska**. Each Family Partner is recruited from and based within the community in which he/she resides.

In addition, Families CARE coordinates Youth Encouraging Support (YES), a group of 200–300 youth in Region 3, who work to educate professionals, families, and peers on mental health issues and to reduce the stigma within their communities. YES also provides support to other youth who have mental health disorders and provides a youth voice within the local systems of care. Youth and parents who were interviewed applauded the work of YES and indicated that these connections with other youth make a significant difference in the life of each youth. Family Partners and YES are programs that Families CARE operates through its contract with Region 3 Behavioral Health Services (BHS). Funding for the contract comes from the case rate for the Integrated Care Coordination Unit (ICCU). In addition, YES applies for small grants for specific activities, and the youth fundraiser.

**Choices Choices**

***Purchasing Family Advocate Services from Family Organization***

Family advocates are paid by **Choices** on a fee-for-service basis. Every family served has access to a family advocate to accompany them to child and family team meetings and for other sources of support. Family advocates are employed by the family organization (Rainbows) and are available on an as-needed basis. They are funded fee-for-service to provide family mentoring and support.



**Wraparound Milwaukee** **Wraparound Milwaukee**

***Purchasing Family and Youth Peer Support***

**Wraparound Milwaukee** pays for family peer support and youth peer support on a fee-for-service basis. Family and youth peer support are provided through individuals and agencies that are part of Milwaukee Wraparound’s extensive provider network. They are paid for through Milwaukee’s blended funding pool.

► **Incorporate Financing to Provide Families and Youth with Choice of Services and/or Providers**

Most of the sites use an individualized care planning process with child and family teams in which the youth and family are integral to decision making about the services and supports that will be provided. In addition, the sites also offer choices of providers to families and youth when possible.

**AZ** **Arizona**

***Using Individualized Care Process and Offering Options of Providers***

**Arizona** stakeholders believe that the managed care structure, which allows families choice of providers, and the broad benefit design allow families choice, as well as the Child and Family Team process that closely involves families. In addition, the system can enter into individual contracts with a provider that is outside the managed care network if there is a need for the service. These are known as “single case agreements”. Also, the system uses flex funds (though limited) to support family choice.

**HI** **Hawaii**

***Offering Options of Providers***

Financing allows for families and youth to have some choice of services and/or providers. For example, options are available for providers of intensive in-home services, and attempts are made to address needs based on gender, ethnicity, language, etc. However, in some remote areas where there are few providers, it is difficult to offer choices. In some areas of the state, providers are flown in to provide services on a weekly basis; ferries are used in cases in which islands are closer, such as between Maui and Lanai. Family members reported that due to limited resources, shortages of providers, and high rates of turnover among providers in many areas, in actuality, few choices of services or providers may be available to families and youth, particularly in rural communities and smaller islands.

---

**Choices** **Choices**

***Using Individualized Care Process and Offering Options of Providers***

In child and family team meetings, families are offered options of providers if there is a sufficient volume of providers for the services in question. To the extent possible, providers of services are customized to the community or neighborhood in which the family resides, with the goal of establishing connections with providers that families will be able to maintain independently after their involvement with **Choices** has ended. Typically, two or three suggestions of providers for a service are brought to the child and family team meeting. The family is able to choose or may rely on the recommendation of the care coordinator.

**Wraparound Milwaukee** **Wraparound Milwaukee**

***Using Individualized Care Process and Offering Options of Providers***

The child and family team, on which the family and youth are key players, determines the array of services and supports for a child and family, drawing from a very broad provider network of over 200 providers and 85 services and supports and access to flexible, individualized (e.g., one-time) supports as well. The plan of care developed by the team details the specific services and supports that will be provided, but not the specific provider. The family itself may choose the provider. This also creates a built-in quality improvement check for the system because if families are not choosing particular providers, the system will have that information and can begin to analyze the underlying reasons.

## ► Incorporate Financing to Train Providers on How to Partner with Families and Youth

### **Strategies include:**

- Providing payment and supports for family and youth participation at the policy level
- Contracting with family organizations for participation in policy making
- Incorporating other strategies to finance family and youth participation at the policy level
- Financing training and leadership development to prepare families and youth for participation in policy making

The sites use various approaches to finance training for providers on how to partner with families and youth.

### **AZ** Arizona

#### ***Financing Training for Families and Providers***

**Arizona** has spent \$7 million since the JK settlement agreement in tobacco settlement monies, as well as discretionary and formula grants and Regional Behavioral Health Authority (RBHA) investments, to pay for training and coaching of families, providers and others to develop a statewide practice approach designed to actualize Arizona’s vision of family-centered practice and the 12 system of care principles. The Family Involvement Center partnered with the Value Options (VO) training department, Comprehensive Services Providers (i.e., core service agencies), and others designated by VO to design a curriculum on how to partner with families and youth. (See [www.familyinvolvementcenter.org](http://www.familyinvolvementcenter.org))

### **HI** Hawaii

#### ***Incorporating Focus on Partnering with Families and Youth in All Training***

Training for providers always includes a focus on partnering with families. Family members are employed as trainers and provide training on effective partnerships and collaboration with families. There also are resources in the current **Hawaii** Families as Allies budget to train providers in how to partner with families and youth. The state points out that just being in the same room does not necessarily result in meaningful family participation or effective partnerships between providers and families. The state plan is for parent partners to provide group and individual training to line staff on partnering with families and youth.

In addition, the second annual Young Adult Support Group Planning Summit will be held this year with the theme of “Why Not Me?” This will be used as a vehicle to share with providers the vision of youth voice and youth involvement and provide training about how to partner with youth.

**VT Vermont**

***Financing the Family Organization to Train Providers***

**Vermont's** Department of Mental Health has a long-standing partnership with the Vermont Federation of Families for Children's Mental Health, which was the first state chapter of the national Federation of Families for Children's Mental Health organization. The Federation has received funding from its inception from the Department of Mental Health, as well as significant multi-year federal grant funds, to engage in a variety of ways with parents, providers and policymakers in building the system of care with strong family participation. The Federation's current state contract (\$93,000), along with other resources, funds efforts with the Department of Mental Health to help design and conduct training for mental health, other state agency and local provider agency staff, and to work directly with family members and others in improving mental health services and policies. The Federation conducts extensive family outreach, education and leadership development and serves as the family organization representative on several formal advisory and review bodies.

**Choices Choices**

***Using a Community Resource Manager to Train Providers***

The community resource manager is the designated individual in each site who works closely with providers, including identifying providers to participate in the network; negotiating rates; and arranging for, coordinating, or providing training on best practices, innovations, etc. One aspect of the training for providers in the network is on family-driven care. Community resource managers arrange for training provided by family members; family members employed by the family organization, Rainbows, can provide such training locally or can travel to other sites. The contract with Rainbows covers these costs.

**Wraparound Milwaukee Wraparound Milwaukee**

***Providing Training to Providers***

**Wraparound Milwaukee** trains all providers in its underlying principles, values and operating procedures, in the child and family team concept and operations, and in the wraparound approach. It also tracks fidelity through its quality improvement (QI) system.

## B. Finance Family and Youth Involvement in Policy Making

### ► Provide Payments and Supports for Family and Youth Participation at the Policy Level

*Arizona, Hawaii, Vermont, Central Nebraska, Choices, and Wraparound Milwaukee* provide payments and supports for family and youth participation at the policy level. The mechanism used in all of these sites is a contract with a family organization which, in turn, provides payments and supports to family members and youth. Typically, supports include stipends and, on an as-needed basis, may also include transportation, child care, and food.

**AZ** Arizona, **HI** Hawaii, **VT** Vermont,  
**NE** Central Nebraska, **Choices** Choices, and  
**Wraparound Milwaukee** Wraparound Milwaukee

#### ***Contracting with a Family Organization to Provide Payments and Supports for Policy-Level Participation***

- In **Arizona**, Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/BHS) uses federal discretionary and block grant dollars to support family involvement in policy making. There is not a strong youth involvement effort yet, but family involvement is a major priority. In the space of about four years (since the JK settlement agreement), family partnership has grown considerably at the state level within ADHS/BHS and at the plan level such that Arizona’s family leaders are recognized nationally. Both ADHS/BHS and Value Options in Maricopa reported that they would not be as far along in their reform without the family partnership component. They believe that the philosophical shift among providers and plans is due largely to families being “at the table” and to families providing technical assistance to providers and plans. Both the state and Value Options reported that the family organizations taught them how to engage families at system and practice levels and support families, not just as advocates, but as system and service delivery partners. Families served on the committee to select the contracted Regional Behavioral Health Authorities (RBHAs). Providers employ family members as family support partners and as staff, and families serve on agency boards. The state contracts with MiKid (the statewide family organization) and the Family Involvement Center in Maricopa County to provide stipends for family involvement in policy making and to ensure that families have access to other supports to participate effectively, as needed. The state also paid the first year dues of these organizations to belong to the Arizona Council of Providers to ensure that their voice is heard at that level of the system.

- In **Hawaii**, most of the supports for family/youth participation at the policy level are provided through a contract with Hawaii Families As Allies (HFAA), the statewide family organization. The Child and Adolescent Mental Health Division (CAMHD) has been a strong advocate and supporter of family and youth involvement. CAMHD's contracts with provider agencies require the submission of youth engagement and family engagement policies that include a statement of the agency's commitment to involve youth and families in all levels of the organization, as well as a means of ensuring that youth and family members are engaged in their own treatment plan development and evaluation, organizational quality assurance activities, and organizational management and planning activities.
- In **Vermont**, the state system of care statute prescribes funding for participation for parents/family members and family organization representatives on local and state interagency teams and various advisory panels. Vermont law (Act 264 – Title 33 Human Services §§ 4301-4305) mandates family participation at all levels of the system of care (individual case/treatment teams, Local Interagency Teams [LIT], State Interagency Team [SIT] and State Advisory Board). The SIT has a Case Review Committee that provides assistance to local teams as they work to identify, access, and/or develop resources to serve children and youth in the least restrictive settings appropriate to their needs. This review committee has representatives from the lead state agencies and the Vermont Federation of Families for Children's Mental Health, specifically. Support for individual family member representation is paid by state mental health funds. Financing for the family organization representatives is covered under the state contract with the Vermont Federation of Families for Children's Mental Health (currently \$93,000), which includes participation in system of care decision-making and support roles.
- In **Central Nebraska**, a contract with the family organization, Families CARE, is the mechanism used to support family involvement in policy making. Families CARE reimburses families for their expenses (provides meals, gas money, and child care).
- In **Choices**, support for family participation at the system level is provided through a contract with Rainbows, the family organization. The Governor's Office in Indiana offers scholarships for families to attend policy meetings, conferences, and training.
- In **Wraparound Milwaukee**, a contract with the family organization, Families United for Milwaukee County, provides a vehicle for support of family participation at the policy level. The family organization pays for parent stipends to participate in policy and team meetings and provides other supports.

## ► Contract with Family Organizations for Participation in Policy Making

Contracts with family organizations are the most frequent vehicle used to ensure family participation in policy making. **Arizona, Hawaii, Vermont, Central Nebraska, Choices,** and **Wraparound Milwaukee** contract with family organizations to fulfill a wide variety of policy making and system management roles, including serving on committees and advisory bodies; participating in evaluation activities; providing training; providing family advocates, peer mentors, and ombudspersons; developing and disseminating information; and organizing and facilitating youth groups and youth councils.

### **AZ** Arizona

#### **Contracting with Two Family Organizations**

The **Arizona** Dept. of Health Services, Division of Behavioral Health Services (ADHS/BHS) uses both discretionary (e.g., federal State Infrastructure Grant) and formula grant dollars to contract with two family organizations — MIKID, a statewide family organization, and the Family Involvement Center (FIC) in Maricopa County. The family organizations hold both mini-conferences and a statewide conference to reach more families. At the time of the study, ADHS/BHS was issuing a new Request for Proposals (RFP) for consumer and family involvement at the policy level — for example, to support families to serve on committees, to participate in practice evaluation, to create a hotline for families, etc. The RFP includes a priority on establishing a family advocacy center serving Latino families. MIKID and FIC submitted a joint proposal to ensure statewide family involvement at the policy level and to clarify their respective roles. The state also received a federal Center on Substance Abuse Treatment (CSAT) adolescent substance abuse grant and included both MIKID and FIC in the grant.

In Maricopa County, the FIC is seen as an “extension of Value Options” (VO) in terms of expanding VO’s capacity to advance system of care goals. (Initially, FIC got started with a small grant from St. Luke’s Health Initiative and then became funded with system dollars.) VO has funded FIC for several years, and FIC has also been a direct service provider within the VO provider network since 2005. VO also funds MIKID. VO’s contract with FIC is for \$900,000 for “system transformation” activities in Maricopa County, including staffing and participating on the Children’s Advisory Committee for VO, family recruitment and training, organizing open education opportunities for families, information and referral, co-facilitation of meetings, recruitment and training of family support partners (who are out-stationed with each of the Comprehensive Service Providers), and technical assistance to providers and others on family partnership. Every family enrolled with VO receives a Family Handbook developed by FIC and is invited to attend orientation sessions conducted by FIC. VO also has several full-time family members on staff, with two devoted to the children’s system at the time of the site visit.

At the time of the site visit, FIC received the following funding:

- Contract with VO for the “system transformation” activities noted earlier, including: recruit family support partners for provider agencies in the VO network, train and coach family members and providers in a family partnership model, train and supervise family members to participate in performance improvement reviews, and pay stipends to families.



- Contract with VO to be a Medicaid Comprehensive Services Agency (CSA) provider (all billable work has to be face-to-face contacts) and to hire eight family support partners to provide family-to-family services as part of the provider network. Also, after the site visit for this study, FIC became licensed as an outpatient behavioral health provider, which allows it to bill for telephone contact and provide case management, in addition to providing respite, peer support and family education as a CSA Medicaid provider.
- Federal SIG grant funding from the state to expand the family movement.

For more information about the Family Involvement Center, see <http://www.familyinvolvementcenter.org>

## **HI** Hawaii

### ***Contracting with the Statewide Family Organization***

CAMHD contracts with **Hawaii** Families as Allies (HFAA), the statewide family organization for participation in policy making and system management. The first such contract was executed in 2002. State general fund dollars and federal block grant funds are used to fund the activities of the family organization. Funding levels were at approximately \$722,000 last year. HFAA reports a staff of 17–18 people who are available to participate on a range of committees and other policy-level activities through the contract resources. CAMHD may finance transportation to support some policy-level participation outside of this contract; this is financed through flexible funds for ancillary services. In particular, assistance is available if transportation to another island is necessary.

The family organization is providing assistance in the newly received federal system of care grant focusing on youth in transition to adulthood. Among other activities, assistance is being provided in establishing a young adult support organization and preparing/mentoring youth to participate in policy making activities. Family members also serve as co-chairs with professionals on the Community Children’s Councils (CCCs); there are 17 of these in the state. These councils meet monthly to plan for and assess the strengths and needs of the children’s mental health system in their respective communities. Quarterly statewide meetings of the CCC chairpersons are held. These councils were initiated as a result of the Felix lawsuit. During the lawsuit, HFAA was used as a vehicle for supporting family involvement on the CCCs.

Parent partners are employees of HFAA whose role involves supporting parents in advocating for their children and themselves. Parent partners attend meetings such as individual education plan (IEP) meetings and court proceedings with families, conduct workshops and support groups for families, and support families in a variety of other ways. Parent partners are tied to the various Family Guidance Centers, and they serve on Family Guidance Center committees and management teams representing the interests of and advocating for families.

HFAA reported initiating a strong marketing campaign to create greater awareness of HFAA and the various supports that the organization offers. The contract with Hawaii Families as Allies specifies a scope of work that involves providing family involvement and support to families with youth experiencing emotional and/or behavioral challenges in the state including:

- Ensure that the family perspective at the community and state level is effectively presented and considered in all policy decisions (including providing representatives for CAMHD Executive Management Team, State Mental Health Council, the children's policy group of the Governor's Cabinet, and various CAMHD committees)
- Develop, implement, and coordinate a program on a broad range of topics relevant to enhance attitudes, skills, and knowledge of youth and families
- Develop, implement, and evaluate a program of training that addresses a broad range of topics including, but not limited to educational issues, health issues, child welfare issues, juvenile justice issues, substance abuse issues, effective parenting, and community collaboration
- Disseminate information by obtaining or developing documents (flyers, checklists) that provide information using family friendly language
- Publicize the availability of documents through the newsletter of family-focused organizations
- Disseminate and distribute documents through all suitable avenues including developing a web site
- Conduct workshops on specific topics related to families in the community
- Organize, widely publicize and host at least one conference annually for parents, foster parents, and caregivers of youth with emotional and/or behavioral challenges
- Organize and facilitate a Youth Council comprised of youth to conduct public awareness and peer support activities developed by youth
- Operate and publicize a statewide phone line to respond to requests for information and help in accessing services and support for children with emotional and/or behavioral challenges
- Employ Consumer/Family Relations Specialists to be accessible via the statewide phone line to advise families about appropriate services for children with emotional and/or behavioral challenges
- Develop and maintain two resource manuals of available services and supports (an Empowerment Resource Manual with information identifying community resources and a Recreational Resource Manual with information about recreational, leisure, and educational resources)
- Provide comprehensive peer support for families of children with emotional and/or behavioral challenges by recruiting, training, and supervising Parent Partners who will serve families in the community
- Assist families seeking help for their children with emotional and/or behavioral challenges to access and navigate through the available services
- Increase social acceptance and reduce the stigmatization and bullying of youth with emotional and/or behavioral challenges on a statewide level.
- Participate in the CAMHD Strategic Plan
- Collect and report information about activities and outcomes of those activities, and regularly use evaluation results to identify and address areas that need improvement.

## **VT** Vermont

### ***Contracting with the Statewide Family Organization***

The state has a contract with the **Vermont** Federation of Families for Children’s Mental Health (currently \$93,000 and indexed for increases) for participating in system of care decision-making and advisory roles, for developing and carrying out parent and provider training activities, for outreach, peer support, and referral, and conducting special projects to strengthen parent/ family awareness about the system of care and its resources. The Federation also serves as a resource to the state and local mental health agencies, and works as well to grow parent leadership on children’s mental health. This includes making connections between family members ready to move into system-level work and policy groups and those committees and groups looking for new members at the regional and state levels.

## **NE** Central Nebraska

### ***Contracting with a Family Organization***

The behavioral health system for children and families in Central Nebraska operates as a “three legged stool”, including 1) Region 3 Behavioral Health Services (BHS); 2) Nebraska Department of Health and Human Services, Central Service Area, Office of Protection and Safety; and 3) Families CARE. When Nebraska received a CMHS grant in 1997, Region 3 called families together to talk about how to build a system of care and to learn what families needed. Parents told them they needed an independent family organization; thus, Families CARE was created to provide support, advocacy, education and care management services for families who have children with emotional and behavioral difficulties. Region 3 BHS also contracts with Families CARE for certain evaluation components that measure wraparound fidelity and family and youth satisfaction. Initially, CMHS grant funds were used to fund Families CARE. Now Region 3 BHS contracts with Families CARE for \$472,000/year (with funds saved from the Integrated Care Coordination — ICCU program case rate). This began as a cost reimbursement contract, and then moved to 8% of the case rate, based on actual costs.

**Choices Choices**

***Contracting with a Family Organization***

**Choices** contracts with Rainbows, a family organization in Marion County, **Indiana** in the amount of \$225,000 per year. The contract supports four full-time staff, offices (provided by Choices at a minimal rent), technology, etc. The staff of Rainbows is employed by Choices, and, as such, receives the Choices benefit package. Essentially, the Choices contract supports the infrastructure for the family organization. Although there may be the perception that the family organization is “owned” by Choices, this is the only viable financing strategy to support the organization. As part of the contract, Rainbows is required to operate a hotline, offer a family support group with monthly meetings, a newsletter, trouble shooting, training, and public speaking. Participation in policy making functions related to Dawn is included in Rainbow’s role, such as participation on the Marion County System of Care Collaborative. In addition to these functions, Rainbows staff is paid for additional services on a fee-for-service basis. These include mentoring — either mentoring a child or an entire family — or serving as a family advocate. Family advocates can bill at the market rate for mentors. They accompany the family to child and family team meetings and provide other supportive services.

**Wraparound Milwaukee Wraparound Milwaukee**

***Contracting with a Family Organization***

**Wraparound Milwaukee** contracts with Families United for Milwaukee County at \$300,000/year. The family organization pays for parent stipends to participate in policy and team meetings, conducts training of care coordinators, employs the education advocate, holds family events, provides family education and support, provides 1:1 family peer support, and publishes a newsletter. There is also a Youth Advisory Committee, but it is not as well established.

► **Finance Training and Leadership Development to Prepare Families and Youth for Participation in Policy Making**

Leadership development activities are financed in some of the sites to prepare families and youth for participation in policy making and system management activities.

**HI Hawaii**

Among other activities, the contract with **Hawaii** Families As Allies (HFAA) includes family leadership training. The curriculum developed for this purpose is now used nationally. The Leadership Academy is comprised of three days of training and is held 3 times per year, according to HFAA. The training provides family members with a range of knowledge and skills, including: understanding the legislative system, the structure of the mental health system, how to build relationships with policymakers, how to speak in front of an audience, how to make their voices heard, etc.

**AZ** Arizona, **VT** Vermont,

**Wraparound Milwaukee** **Wraparound Milwaukee**

- **Arizona** has spent \$7 million to date in tobacco monies, discretionary and formula grants and RBHA investments to pay for training. This has included training and coaching of families related to policy level participation.
- In **Vermont**, the contract with the Vermont Federation of Families for Children’s Mental Health provides training and supports for families and others. These trainings focus on a range of issues, from service-related matters to leadership development. A current SAMHSA grant also supports the Federation as the Vermont Statewide Family and Consumer Driven Leadership Team “to drive the implementation, sustainability and improvement of effective mental health and substance abuse prevention and treatment services for children, youth, young adults and their families.”
- In **Wraparound Milwaukee**, the contract with Families United includes this type of training for families.

**C. Finance Services and Supports for Families and Other Caregivers**

**Strategies include:**

- Incorporating strategies under Medicaid and other financing mechanisms that allow services and supports to families
- Financing family organizations to provide services and supports

► **Incorporate Strategies Under Medicaid and Other Financing Mechanisms that Allow Services and Supports to Families**

The sites have incorporated strategies to ensure that services and supports can be provided to families and are not limited to the “identified child.” These include coverage under Medicaid, use of other agencies’ funds, use of flex funds, and use of blended or braided funding structures supported by case rates.

**AZ** Arizona

**Covering Services and Supports to Families Under Medicaid**

Medicaid can pay for family education and peer support, respite, behavioral management skills training and other supports to families if these supports are geared toward improving outcomes for the identified child. The child does not have to be present. Medicaid also can be used to pay for transportation and interpretation services for families. Non-Medicaid allowable services — for example, certain cultural supports, such as Native healers — can be paid for with non-Medicaid

dollars in the Regional Behavioral Health Authority (RBHA) capitation. Arizona also defines “family” broadly. The Medicaid Covered Services Guide provides the following definition of family and guidance regarding coverage of services to family members.

“For purposes of services coverage and this guide, family is defined as: The primary care giving unit and is inclusive of the wide diversity of primary care giving units in our culture. Family is a biological, adoptive or self-created unit of people residing together consisting of adult(s) and/or child(ren) with adult(s) performing duties of parenthood for the child(ren). Persons within this unit share bonds, culture, practices and a significant relationship. Biological parents, siblings and others with significant attachment to the individual living outside the home are included in the definition of family. In many instances, it is important to provide behavioral health services to the family member as well as the person seeking services. For example, family members may need help with parenting skills, education regarding the nature and management of the mental health disorder, or relief from care giving. Many of the services listed in the service array can be provided to family members, regardless of their enrollment or entitlement status as long as the enrolled person’s treatment record reflects that the provision of these services is aimed at accomplishing the service plan goals (i.e. they show a direct, positive effect on the individual). This also means that the enrolled person does not have to be present when the services are being provided to family members.” (See [http://www.azdhs.gov/bhs/bhs\\_guide.pdf](http://www.azdhs.gov/bhs/bhs_guide.pdf) for Arizona’s Covered Services Guide)

At the time of the visit, the Family Involvement Center in Maricopa County had just agreed to develop for the child welfare system community/family supports for families at risk but whose children are not yet removed from home (in a “Family-to-Family” approach) in one zip code in the county. Child welfare also was launching a “Building Better Futures” initiative that would assign parent mentors who had had involvement with child welfare to at-risk parents. Child welfare is hoping to recruit these parent mentors through its substance abuse providers. Child welfare has used the MAPP training (National Model Approach to Partnership in Parenting out of Atlanta) and indicated that the Arizona Dept. of Health Services, Division of Behavioral Health Services (ADHS/BHS) also adapted this model statewide with a therapeutic overlay for its therapeutic foster care providers.

## **HI** Hawaii

### ***Covering Services and Supports to Families Under Medicaid***

Medicaid allows services and support to be provided to families in addition to the identified child, and for which the identified child does not necessarily have to be present. For example, family therapy is billable even if the child is not present, and for young children, the family can receive services to address issues related to the child, even if the child is not present (e.g., substance abuse). For services not covered by Medicaid, funds for ancillary services are used to finance services and supports to families/caregivers. The role of case managers includes helping families to access needed services through the adult mental health system or other systems or agencies as needed.

Additionally, the contract with **Hawaii** Families As Allies (HFAA), the statewide family organization, is used to provide services and peer supports to families/caregivers. HFAA would like to deliver a parent skills training program as a billable service under Medicaid.

**NE Central Nebraska**

***Using Flexible Funds to Finance Services to Families***

The Professional Partners Program includes flex funds that can be used to pay for treatment and services when a family does not have access to a third party payer. When care coordinators request flexible funds, they must show how using the funds will lead to specific outcomes. There is no charge to families for the care coordination they receive when they are enrolled in Professional Partners Program or the Integrated Care Coordination (ICCU) program.

At the state level, \$310,000 has been set aside (\$274,000 from the Division of Protection and Safety [child welfare] and \$36,000 from the Division of Behavioral Health Services) to serve family members of children served through the five ICCUs across the state. The care coordinator and family determine service needs, and use these flex funds to purchase some of these services.

**Choices Choices and**

**Wraparound Milwaukee Wraparound Milwaukee**

***Using Case Rates and Blended Funds to Finance Services to Families***

- In **Choices**, the case rate approach offers complete flexibility to provide whatever services and supports are needed by the child and family with no medical necessity or prior authorization necessary. The child is not required to be present in order to provide services to parents and other family members, including family therapy, alcohol or drug treatment, and others. Choices maintains data on the wide range of services and supports provided to families. Flexible funds can be used to finance supports to families, including transportation (bus, car repairs, etc.), housing, utilities, clothing, food, summer camps (including for siblings), home repairs, and others. The expenditures must be within the care plan structure, and the plan must document how such expenditures will support the service plan goals for the child and family.
- In **Wraparound Milwaukee**, services to family members are financed through its blended funding approach. It also pays for substance abuse services for parents if necessary and has partnered with the adult substance abuse system to adopt a wraparound approach.



## ► Finance Family Organizations to Provide Services and Supports

In some sites, family organizations can provide specific services and supports, with resources for these services included in contracts with these organizations or by allowing them to bill Medicaid.

### **AZ** Arizona

#### ***Using Family Organizations as Direct Service Providers***

The family organizations not only receive contracts from the state and from individual Regional Behavioral Health Authorities (RBHAs), but they also can be direct service providers. The Family Involvement Center (FIC) in Maricopa, for example, is a Community Service Agency and provides direct services like respite and behavioral coaching. (Subsequent to the site visit, FIC also became licensed as a behavioral health provider, which allows it to provide case management). Medicaid billings thus generate revenue for the organization. In addition, each of the Comprehensive Services Providers (CSPs) in the Value Options network in Maricopa County must have family support partners on staff, who are paid for by the managed care system. These family support partners can provide services in any location (e.g., school, court, home, etc.).

As part of the JK settlement agreement, Medicaid expanded covered services to include a new provider type, called a “community service agency,” (CSA) to allow family organizations and others to be funded like a licensed Medicaid provider. Both FIC and MiKid (the statewide family organization) became CSAs, authorized to provide certain rehabilitation services. As a CSA, FIC can bill Medicaid for rehab services, including skills training and development and health promotion, and support services, including peer and family support, respite and personal care services. One challenge noted by families, however, is that they can only provide services to families referred by the CSPs; in other words, they cannot serve walk-ins directly. A need for FIC services has to be documented in the child and family team plan of care, and families access the CFT process through the CSPs. Families noted that on the adult side, the system funds adult drop-in centers that can serve adults directly, and FIC is advocating for a similar arrangement on the child/family side where FIC and MiKid would get direct service funding.

### **HI** Hawaii

#### ***Using a Family Organization as a Direct Service Provider***

**Hawaii** Families As Allies is receiving training to provide Common Sense Parenting. However, there is concern about shifting this organization to a provider agency, rather than an advocacy and peer support organization. All provider agencies are now obligated through their contracts to have parent and youth specialists on staff to address issues and partnerships with families and youth. The requests for proposals (RFPs) for provider agencies specify this and request the submission of position descriptions with other application materials.

Consumer and family-run services are supported through Medicaid, block grant, and general revenue funds. Block grant and general funds finance parent partners, parent skills training, peer mentoring services for youth, and parent-to-parent supports. An attempt is being made to have all of these services covered under Medicaid through an amendment to the state plan; approval is pending.

**Choices Choices**

***Using a Family Organization as a Direct Service Provider***

In **Indiana**, the family organization (Rainbows) is a provider of some services. In this role, it is treated like any other service provider and is paid on a fee-for-service basis for services, such as mentoring. Financing comes from the case rates. Services provided include family-to-family mentoring. In addition, members of the organization currently are being trained to offer a family training program, Common Sense Parenting. Currently, the county child welfare system contracts with Rainbows to provide Common Sense Parenting and has begun to provide this service to Dawn families. The trainers will be paid to provide this training. Rainbows also provides parent support groups, financed as part of the contract with the family organization.

**VT Vermont, NJ New Jersey and**

**Wraparound Milwaukee Wraparound Milwaukee**

***Using Family Organizations as Direct Service Providers***

- **Vermont's** Department of Mental Health has a contract with the Vermont Federation of Families for Children's Mental Health (currently \$93,000 and indexed for increases) for a range of decision-making and advisory roles, as well as for some direct services. Direct services include developing and carrying out parent and provider training activities and peer support.
- In **New Jersey**, Family Support Organizations (FSOs) are funded via contract with the state in every region and are financed using a combination of state general revenue and Medicaid administrative case management dollars. They are family-run, not-for-profit organizations designed to ensure that the family voice is incorporated at the system and service level. The FSO acts as peer support for families and as a guide for professionals. The Care Management Organizations are required to utilize the services of the FSOs by way of a Family Support Coordinator. The FSOs provide advocacy, information, referral, education, and mentorship.
- In **Wraparound Milwaukee**, Families United is contracted to provide family peer support and educational advocacy.

## V. Financing to Improve Cultural and Linguistic Competence and Reduce Disparities in Care

A core value of systems of care is that they are culturally and linguistically competent, with agencies, programs, and services that respect, understand, and are responsive to the cultural, racial, and ethnic differences of the populations they serve. In recognition of the unique cultural backgrounds of children and families served within systems of care, financing strategies are needed to incorporate specialized services, culturally and linguistically competent providers, and translation and interpretation. Financing strategies also are needed to support leadership capacity for cultural and linguistic competence at the system level and to allow for analysis of utilization and expenditure data by culturally and linguistically diverse populations, which contributes to the identification of disparities and disproportionalities in service delivery. Systems of care also must incorporate strategies to proactively address the disparities in access to care and in the quality of care experienced by culturally and linguistically diverse groups, as well as in underserved geographical areas.

### Financing Strategies Include:

**A. Provide Culturally and Linguistically Competent Services and Supports**

**B. Reduce Disparities in Access to and Quality of Services and Supports**

### A. Provide Culturally and Linguistically Competent Services and Supports

***Strategies include:***

- Financing specialized services
- Incorporating financing and incentives for culturally and linguistically competent providers, nontraditional providers, and natural helpers
- Financing translation and interpretation
- Analyzing utilization and expenditures by culturally and linguistically diverse populations
- Financing cultural competence coordinators and/or leadership capacity at the state or local levels

#### ► Finance Specialized Services

Some of the sites cover “cultural” services, that is, specialized services that are specifically designed to respond to the ethnic and cultural characteristics of children and families served.

## **AZ** Arizona

### ***Covering Cultural Services***

Many covered services within the managed care system, such as counseling, can be provided in any location, including locations that may be more culturally appropriate, such as a sweat lodge. Translation and interpretation are services covered by Medicaid. Certain cultural activities, such as traditional Native healing, can be paid for by the managed care system, though not with Medicaid dollars, but using the other dollars in the system. The managed care system also uses “promotores,” outreach workers and counselors for the Latino community, which it covers in a number of ways, e.g., as “health promotion,” family support, or peer support under Medicaid.

The state used funding from a federal Center for Substance Abuse Treatment grant to develop a cultural competence training curriculum. The state also developed a Practice Improvement Protocol related to cultural competence and requires RBHAs to do cultural organizational self-assessments. For information about Arizona’s Practice Improvement Protocol, see: [http://www.azdhs.gov/bhs/provider/sec3\\_23.pdf](http://www.azdhs.gov/bhs/provider/sec3_23.pdf)

## **HI** Hawaii

### ***Covering Cultural Services***

The entire state is highly diverse with a multi-ethnic and multi-cultural population. There is financing for specialized services to culturally/linguistically diverse populations. For example, interpretative services are provided through flexible funding for ancillary services and supports, as are nontraditional services and supports, such as martial arts provided as a therapeutic service for children. Traditional healer services and other Eastern approaches to treatment (such as Asian healer services) are funded under Medicaid or mental health general fund resources. The state is attempting to integrate Eastern and Western approaches to medicine to meet the needs of the diverse cultural and ethnic groups services, including Chook, Samoan, Micronesian, Chinese, and other cultures.

## **AK** Bethel, Alaska

### ***Covering Cultural Services***

Yukon-Kuskokwim Health Corporation (YKHC) sponsors the following projects that are designed to offer and support culturally competent services and supports:

#### ***Family Spirit Project***

Family Spirit Project is a collaborative effort of the communities of the Yukon-Kuskokwim region, the Department of Health and Social Services, Division of Alcohol and Drug Abuse, the Office of Children’s Services, the YKHC and other community providers in the Delta. Emphasizing traditional family life and values, the collaboration builds a community development model to strengthen families so that children will be safer in their homes. Parents who could lose their parental rights due to abuse and neglect of their children are encouraged to enter substance abuse treatment in a culturally appropriate and supportive manner. These parents are a priority population for YKHCs substance abuse treatment services.

### **Community Holistic Development**

Drawing on local resources, the Holistic Development Program conducts presentations on grief processes, youth conferences, healing circles, “Spirit Camps,” and other health promotion activities. This program integrates the cultural, traditional, and spiritual values of the people in partnership with other family-based counseling services.

### **Choices Choices**

#### **Covering Cultural Services**

In **Choices**, any service can be provided within the case rate structure, depending on the child and family’s need and what is included in the individualized care plan. If the child and family team identifies a service need that is not readily available, it is the responsibility of the care coordinator and community resource manager to look for an appropriate resource. Culture and language are considered by child and family teams in developing the service plan and identifying resources to provide services and supports. For example, some African American youth have attended a camp program that uses a retreat approach for rituals around the transition from boys to men.

## **► Incorporate Financing/Incentives for Culturally and Linguistically Competent Providers, Nontraditional Providers, and Natural Helpers**

Sites have incorporated financing and various types of incentives for culturally and linguistically competent providers, including natural helpers and traditional healers.

### **AZ Arizona**

#### **Incorporating Requirements in Contracts**

There are clear expectations in Regional Behavioral Health Authority (RBHA) contracts with providers related to serving culturally diverse populations, and fiscal penalties may be attached to serving an inadequate number of culturally diverse members. These are specific to each RBHA contract. There also are requirements for recruitment and retention of Latino providers, and RBHAs are required contractually to have specialized Native American providers in their networks.

Value Options (VO) in Maricopa County indicated that the state will be conducting cultural competence assessments of providers and may implement direct incentives to providers and/or to RBHAs in the future. VO also indicated that it has implemented both incentives and sanctions for the Comprehensive Service Providers in its network related to access for the Latino population. Providers could receive up to \$10,000 a month depending on their meeting certain access standards (e.g., \$2500 per month if reaching 40% of Latino eligibles).

The state also reported that it is working on a loan forgiveness program for various types of behavioral health staff. (Note. The legislature approved funding for this in fiscal year 2007).

Nontraditional providers, paraprofessionals and natural helpers can be included in managed care networks as community service, or direct service, agencies. For example, the Family Involvement Center (FIC) in Maricopa County and Boys and Girls Clubs in other parts of the state are providers. Also, FIC is developing a teaching video and toolkit as part of its contract with the state (financed through federal State Infrastructure Grant dollars) on use of natural supports. (Note. This video and toolkit are now available. Contact: <http://www.familyinvolvementcenter.org>.)

Also, providers reported that there are “informal incentives” provided by VO in Maricopa. For example, VO loaned a staff person for a year to the People of Color Network in Maricopa to help them develop the infrastructure needed to join the VO Medicaid network.

## **HI** Hawaii

### ***Using Financial Incentives***

Financial incentives are offered for culturally and linguistically competent providers, and provider agencies generally have culturally diverse staff and staff able to speak many languages. The Child and Adolescent Mental Health Division (CAMHD) pays higher rates if the clinician is fluent in the needed language. Providers under contract with CAMHD are required to submit a cultural competence policy to ensure that all employees and subcontractors are trained and supervised in providing services in a culturally aware manner, including requirements for cultural assessment and cultural considerations in the treatment planning process. There also are financing mechanisms for nontraditional services and natural helpers such as Native Hawaiian healers and Asian healers, both funded with Medicaid and mental health general fund resources.

## **NE** Central Nebraska

### ***Providing Language Classes for Providers***

Region 3 Behavioral Health Services funds and hosts a weekly Spanish language class for its Region 3 staff, Families CARE staff and providers.

**Choices** **Choices**

***Recruiting and Developing Culturally Appropriate Providers***

**Choices** has worked with minority communities to identify culturally and linguistically competent providers, as well as nontraditional providers appropriate for particular racial and ethnic populations. Work with the African American community has resulted in the identification of African American treatment foster parents who serve predominantly African American youth. In addition, Choices collaborates with a church, paying for an additional staff person to enable the provision of after school care for youth in this natural, culturally appropriate community setting. Often, culturally appropriate providers are developed on an individual case basis. For example, collaboration with a Korean church was undertaken to meet the support needs of a Korean youth and family. The resources developed for individual youth and families become part of the database and are shared among staff; these resources can then be enlisted in the future on behalf of other clients.

Choices has engaged consultants both in **Indiana** and **Ohio** to assist in doing cultural assessments and in developing strategies to improve cultural and linguistic competence. Consultants also have worked with providers in the provider network (including mentors, therapists, therapeutic foster care agencies, and others) to provide training related to cultural and linguistic competence. In addition, Choices has worked internally to add diversity to its own staff. The staff now is 40% African American.

**Wraparound Milwaukee** **Wraparound Milwaukee**

***Including Diverse Providers in Network***

There are over 40 racially and ethnically diverse providers in Milwaukee’s provider network. Also, the system will pay for interpretation and translation services and uses nontraditional providers. It also tracks use of informal helping supports through its management information (MIS) system.

**Wraparound Milwaukee** believes that its fee-for-service structure does allow diverse providers to compete effectively and that lack of a “guarantee” for a certain service amount has not been an impediment to diverse providers’ participating in the provider network.



## ► Finance Translation and Interpretation Services

All of the sites finance translation and interpretation services either with Medicaid, managed care system resources, or with flexible funds.

**AZ** Arizona; **HI** Hawaii; **NJ** New Jersey; **VT** Vermont;  
**AK** Bethel, Alaska; **NE** Central Nebraska, **Choices** Choices,  
and **Wraparound Milwaukee** Wraparound Milwaukee

*Financing Translation and Interpretation with Medicaid,  
Managed Care System Resources, or Flexible Funds*

- In **Arizona**, translation and interpretation are paid for by the managed care system and are a covered Medicaid benefit. The staff of the Family Involvement Center in Maricopa is 35% Latino and often provides translation services.
- In **Hawaii**, there is financing for translation and interpretation services through flexible funding for ancillary services and supports. The most common languages include Mandarin, Korean, Ilocano, and Tagalog. CAMHD also produces documents in large print and on CD for people with vision impairments.
- In **New Jersey**, translation and interpretation are paid for by the CSA and are a covered Medicaid benefit.
- In **Vermont**, the system of care financing mix supports translation and interpretation services as needed. Local agencies typically subcontract for these services. Medicaid pays for them.
- In **Bethel, Alaska**, the Yukon-Kuskokwim Health Corporation provides and pays for translation and interpretation services using a mix of funding sources.
- In **Central Nebraska**, Medicaid reimburses for interpretation services during treatment. Region 3 maintains a list of interpreters and translators they can call upon.
- In **Choices**, translation and interpretation are financed on a fee-for-service basis as needed, including interpretation for persons with hearing impairments. Choices has staff members who are Hmong and Hispanic and, thus, has internal capability in Hmong and Spanish.
- In **Wraparound Milwaukee**, the system will pay for interpretation and translation services, using its blended funding pool.

---

## ► Analyze Utilization, Expenditures, and Outcomes by Culturally and Linguistically Diverse Populations

Analysis of utilization, expenditure, and outcome data by culturally and linguistically diverse populations allows systems of care to identify potential problems or disproportionalities in access to services, in service utilization, and in the quality and outcomes of care.

### **AZ** Arizona

#### **Analyzing Data by Racial/Ethnic Groups**

The system is able to analyze utilization and costs by racial/ethnic breakdown but does not run this analysis regularly. Instead, it engages in special studies, for example, a study looking at under-utilization of services by the Latino community, and another long term project involving juvenile justice and Value Options to look at over representation of youth of color in the juvenile justice system.

### **HI** Hawaii

#### **Analyzing Data by Racial/Ethnic Groups**

Service utilization, expenditures, and outcomes are analyzed by culturally/linguistically diverse populations. No differences in outcomes by specific groups have been found; the entire state's population is culturally/linguistically diverse, and most youth and their families are multi-ethnic. However, better outcomes have been found for youth eligible for the Medicaid program than non-Medicaid eligible youth, regardless of cultural group. This is attributed to the richer service array available for the Medicaid eligible population.

### **Wraparound Milwaukee** **Wraparound Milwaukee**

#### **Analyzing Data by Racial/Ethnic Groups**

The system does analyze utilization and costs by racial/ethnic breakdown and analyzes disproportionality and disparity issues. It has been able to tap into federal Disproportionate Minority Confinement (DMC) dollars through its partnership with the juvenile justice system. Specifically, Wraparound Milwaukee has reduced placement of African American youth in corrections facilities, which enables the juvenile justice system to draw down DMC monies, which, in turn, it uses to pay **Wraparound Milwaukee**.

## ► Finance Cultural Competence Coordinators and/or Leadership Capacity at State or Local Levels

### **Strategies include:**

- Incorporating financing strategies to reduce racial and ethnic disparities in access and quality of care
- Financing outreach to culturally and linguistically diverse populations
- Incorporating strategies to reduce geographic disparities
- Financing the use of technology to serve underserved geographic areas
- Financing transportation

Some of the sites finance leadership for cultural and linguistic competence — either cultural competence coordinators at state and/or local levels or various types of cultural competence advisory committees or teams.

### **AZ** Arizona, **HI** Hawaii, **Choices** Choices, and **Wraparound Milwaukee** Wraparound Milwaukee **Financing Cultural Competence Leadership**

- In **Arizona**, the Chief of Substance Abuse Prevention in the Arizona Department of Health Services (ADHS) reportedly is a leader in the cultural competence field and has served in an ad hoc position as coordinator for cultural competence activities. At the time of the study visit, the state was looking at use of discretionary grant dollars to fund a cultural competence coordinator position. There is a three-year old Cultural Competence Advisory Committee, which the Chief of Substance Abuse Prevention chairs, and which has developed a framework for cultural competence in the behavioral health system. The committee includes representation from child welfare, juvenile justice, families, etc. The committee devoted its first foundational year to looking at research and data on utilization, disparities, etc. There are three committees: one on data, one on translation/interpretation, and one on training (chaired by the ADHS training coordinator). Each Regional Behavioral Health Authority (RBHA) also is required to have a cultural expert and to conduct a cultural competence organizational self-assessment that leads to a plan for each RBHA. The committee is developing a tool to measure cultural competence at the RBHA level. RBHA Cultural Competency Plans, at a minimum, must address the following:
  - Identification of diverse population groups in the service area
  - Determining and addressing any disparity in access and utilization
  - Outreach strategies to diverse communities
  - Recruitment and retention strategies to attract and develop culturally competent staff
  - Obtaining input and consultation from diverse groups in its service area
  - Collaboratively working with local diverse groups to review service delivery to individuals, families, communities

- Receiving consultation on planning, providing, evaluating and improving services to diverse individuals, families and communities
  - Regular quality monitoring program with indicators that evaluate both the quality and outcomes of services with respect to culturally diverse populations
  - Use multi-faceted approaches to assess satisfaction of diverse individuals, families and communities
  - Monitoring service delivery to diverse individuals
  - Ensuring identification of minority responses in the tabulation of client satisfaction surveys
  - Ensuring cultural competency training is required and obtained by all staff at all levels of the organization(s) providing behavioral health services
  - Ensuring persons’ and families’ cultural preferences are assessed and included in the development of treatment plans.
- In **Hawaii**, as of July 1, 2006, in the Child and Adolescent Mental Health Division’s (CAMHD) new request for proposals (RFP), agencies were asked to establish positions for cultural coordinators/specialists. There is no formal cultural competence coordinator at the state level, although a staff member within CAMHD plays that role.
  - In **Choices**, there was a cultural competence coordinator during the time that Choices had a federal system of care grant, Currently, Choices has a “cultural competence team” that is ongoing and meets quarterly with an outside consultant. The team, currently comprised of Choices staff and representatives of a number of community agencies, receives training, shares resources, discusses diversity challenges, and offers support and suggestions to each other. Choices hosts a Diversity Team list serve so that members can ask questions or share resources electronically.
  - In **Wraparound Milwaukee**, there is a cultural competence committee.

## B. Reduce Disparities in Access to and Quality of Services and Supports

### ▶ Incorporate Financing Strategies to Reduce Racial and Ethnic Disparities in Access and Quality of Care

**Arizona** has implemented strategies to reduce racial and ethnic disparities in care, including outreach, service provision in culturally appropriate sites, special studies to identify and elucidate disparities, and requirements for Regional Behavioral Health Authorities to serve under-served populations (such as the Latino population). Financial incentives in Maricopa County reward providers for meeting access standards for the Latino population.

#### **AZ** Arizona

The managed care system pays for various outreach activities, uses general revenue and block grant dollars to pay for services that are not Medicaid-covered, allows provision of Medicaid services at sites that may be more culturally appropriate, conducts special studies in an effort to identify and reduce disparities, and incorporates contract requirements for Regional Behavioral Health Authorities (RBHAs) to serve under-served populations, such as the Latino population. **Arizona** Department of Health Services, Division of Behavioral Health Services (ADHS/BHS), as part of its “New Freedom” transformation agenda, issued a new advocacy request for proposals (RFP) that called for structured outreach to all culturally diverse populations, including, for example, development of a new Latino family organization and the involvement of faith-based organizations to reach out to the African American community. Value Options (VO) in Maricopa County has implemented both incentives and sanctions for Comprehensive Service Providers related to access for the Latino population. Providers can receive up to \$10,000 a month depending on their meeting certain access standards (e.g., \$2500 per month if reaching 40% of Latino eligibles). The state also has developed practice improvement protocols (PIPs) and a curriculum on cultural competency. ( See: <http://www.azdhs.gov/bhs/policies/cd1-2.pdf>)

### ▶ Incorporate Financing Strategies to Reduce Geographic Disparities

Strategies to reduce geographic disparities were found in several sites.

#### **AZ** Arizona

##### ***Establishing Higher Rates for Home and Community-Based Services***

The fee-for-service rate schedule intentionally pays more for home and community-based versus clinic-based services in an effort to get services to rural areas, among other goals. Also, there is flexibility in the capitation paid to Regional Behavioral Health Authorities (RBHAs) that allows them to pay more for getting providers to rural areas.

## **HI** Hawaii

### ***Providing Incentive Pay to Work in Underserved Areas***

There are special financing mechanisms to provide services in underserved geographic areas. Incentive pay that is 10% above the standard pay scale is offered as an incentive to work in underserved areas. In addition, transportation is paid for providers to fly to the Islands, and travel time is considered billable time. Service utilization patterns and expenditures are analyzed by geographic areas. According to providers, the provider array is different on the smaller islands, and there is a cost differential in providing care in remote areas or areas with a smaller population base. These factors create geographic disparities in the availability of professionals and services.

## **AK** Bethel, Alaska

### ***Using Village Health Clinics***

The entire region is an underserved geographic area. The Yukon-Kuskokwim Health Corporation (YKHC) has put extensive resources into the building and development of village health clinics offering both health and behavioral health services. YKHC's finance system is set up by village and type of service. The system has the capacity to analyze service utilization and expenditures by villages.

Like YKHC, the school districts and the Department of Juvenile Justice struggle to recruit and retain staff to work in the villages. Currently in Bethel, the probation agency is offering incentives for people to get a college degree with an internship that provides needed work experience. The goal is that these individuals will return to Bethel and become probation officers.

## ► **Finance the Use of Technology to Serve Underserved Geographic Areas**

Examples of using technology to address geographic disparities were found in the sites. **Arizona, Hawaii, Vermont,** and **Central Nebraska** are using strategies including telemedicine, video-conferencing, web-based technology, and teleconferencing for services including medication management, psychological and psychiatric evaluation, consultation, and education.

## **AZ** Arizona

### ***Using Telemedicine***

The state has set up a telemedicine system serving remote areas, using federal grant dollars. Medicaid can then be used to pay for certain services provided through the telemedicine system, such as medication management, psychological evaluation, and health promotion and education (for example, teaching parents about attention deficit-hyperactivity disorder). At the time of the site visit, **Arizona** Department of Health Services, Division of Behavioral Health Services (ADHS/BHS), MiKid (the statewide family organization) and Family Involvement Center in Maricopa County were developing an issue paper for the state Medicaid agency on the potential of covering telephone support services.

## **HI** Hawaii

### ***Using Teleconferencing and Video-Conferencing***

Teleconferencing for medication management is used in some of the Islands and is financed by General Fund and Medicaid resources. The state has not been as successful in using video-conferencing due to some of the logistical and technical issues involved. The state has a statewide video-conferencing system. This requires participants to go to specific locations (typically in health centers); advance scheduling is required. The system is used for interviewing, training, meetings of providers, provision of psychiatric consultation, etc. The only direct service that is provided through this system is medication management. Participants have indicated that a two-second delay involved in video-conferencing has been problematic.

## **VT** Vermont

### ***Using Web-Based Technology for Psychiatric Consultation and Telemedicine***

**Vermont** is experimenting with the delivery of psychiatric consultation services using technology (e-mail and web-based “face-to-face” encounters) to provide services in underserved geographic areas. A Department of Labor Grant supports links for telemedicine in three northern very rural and underserved Vermont counties. The state is exploring ways to do more using technology and create additional funding options.

## **NE** Central Nebraska

### ***Using Telemedicine and Teleconferencing***

**Nebraska** was one of the first rural telemedicine sites funded by the federal government. Through funding from the Nebraska Office of Rural Health, the Richard Young Hospital is able to conference in families from 23 counties. They also do medication checks via teleconference. South Central Behavioral Services soon will have telemedicine capacity in two sites.



---

## ► Finance Outreach and Transportation

The sites finance outreach to culturally diverse populations and transportation to increase access to services and reduce disparities. .

### **AZ** Arizona

#### ***Requiring Outreach to Culturally Diverse Populations and “Promotores” Financed by Managed Care System***

Outreach activities can be paid for out of the managed care system. **Arizona** Department of Health Services, Division of Behavioral Health Services (ADHS/BHS), as part of its “New Freedom” transformation agenda, issued a new advocacy request for proposals (RFP) that called for structured outreach to all culturally diverse populations, including, for example, development of a new Latino family organization and the involvement of faith-based organizations to reach out to the African American community. The managed care system also uses “promotores,” health promoters, to reach out to the Latino community. Value Options in Maricopa has set a target for itself of reaching 40% of the eligible Latino youth population.

### **AZ** Arizona and **HI** Hawaii

#### ***Financing Transportation for Families and Providers***

- In **Arizona**, transportation is a covered service in the managed care system. The system can either pay a family for its transportation costs, or pay to bring the service to the family, or pay a transportation provider.
- In **Hawaii**, transportation is paid for families to attend child and family team meetings or for services only available on another island. Additionally, transportation is paid for providers to fly to the Islands, and travel time is considered billable time.

---

## VI. Financing to Improve the Workforce and Provider Network

Systematic attention is needed to develop a workforce with the attitudes, knowledge and skills needed to administer systems of care and to provide services within them. Financing strategies are needed to support a broad, diversified network of providers that is capable of providing the wide ranges of services and supports offered through systems of care and is committed to the system of care philosophy underlying service delivery, such as accepting and valuing the inclusion of families and youth as partners in service delivery and the shift from office and clinic-based practice to an individualized home and community-based service approach. In addition to supporting a broad provider network, workforce development strategies are needed to address pre-service training programs to prepare individuals for work within community-based systems of care, as well as to implement in-service training strategies to help the existing workforce to infuse the new philosophy, values, approaches, and evidence-based practices into their work. The payment rates established for providers must allow systems of care to attract and retain qualified providers within their provider networks and must create incentives for providers to develop and provide home and community-based services.

### Financing Strategies Include:

**A. Support a Broad, Diversified, Qualified Workforce and Provider Network**

**B. Providing Adequate Provider Payment Rates**

### A. Support a Broad, Diversified, Qualified Workforce and Provider Network

***Strategies include:***

- Financing a broad array of providers
- Financing workforce development activities

#### ► Finance a Broad Array of Providers

The sites have implemented several strategies to finance a broad array of providers.

## **AZ** Arizona

### ***Creating New Types of Providers***

Development of a new “community service agency” designation within the managed care system opened up the provider network to new provider types, including family organizations and community agencies, who do not have to be licensed as an outpatient mental health clinic to provide certain Medicaid services. These services include: respite, peer support, habilitation, skills training, and crisis services. Also, there is a category of outpatient provider called a paraprofessional, whose services can be reimbursed under Medicaid. There also is a category called, habilitation workers, that was derived from the developmental disabilities long term care system.

As **Maricopa County** redirected spending from residential treatment centers, it has been able to expand its use of community service agencies, with over 20 contracts currently providing such services as mobile crisis, behavioral coaches, family peer support, etc. To support involvement of these community and family-run organizations, Value Options (VO) in Maricopa County pays them on a prospective basis — 12% of the contract each month; eventually, VO wants to move them to a fee-for-service basis.

## **HI** Hawaii

### ***Financing a Broad Array of Providers***

The state finances a broad array of providers, including nontraditional providers (such as Native Hawaiian healers) through Medicaid and General Fund resources. Supporting a broad, diversified provider array is more challenging on the smaller islands, as there is a cost differential in providing care in remote areas or areas with a smaller population base. These factors create geographic disparities in the availability of professionals and services.

## **Choices** Choices

### ***Building an Extensive Provider Network***

The flexibility in service delivery is supported by an extensive provider network comprised of both agencies and individual practitioners under contract with **Choices**. Some providers may offer a single service, while large agencies may offer multiple services. The network as a whole offers a unique blend of traditional and formal services coupled with nontraditional and alternative services and supports. Providers are not at risk, but rather are paid on a fee-for-service basis. For each individual youth and family, providers are identified to provide the services specified in the service coordination plan. Private psychiatrists or psychiatrists from the affiliated community mental health centers are used for psychiatric assessment and for medication trials and follow-up. (Choices resources cover the cost of medications for children who do not have coverage through Medicaid or through private insurance, or for those whose insurance coverage is exhausted.) In addition, Choices may contract for specialized services to meet a particular need. In this way, the provider network can be expanded and enhanced in a flexible and timely manner in response to the service needs presented by children and their families. The role of the community resource manager in each location is critical in developing and managing the provider network.

## **Wraparound Milwaukee** **Wraparound Milwaukee**

### ***Building an Extensive Provider Network***

**Wraparound Milwaukee** has a very large provider network of over 200 providers, which is diverse and meets the qualifications Milwaukee has developed. Included in the provider network are both individuals and agencies, including over 40 racially and ethnically diverse providers. The network includes clinical treatment providers as well as providers of supports, such as respite and mentoring. No formal contracting with providers is used. Wraparound Milwaukee develops service definitions, rates and standards for 85 different services and supports. Community agencies and individual practitioners are invited during the first 90 days of each calendar year to apply to provide one or more of the services. Wraparound Milwaukee then credentials providers to be part of a qualified provider pool. Child and family teams that develop plans of care and families can draw from any providers on the list. Providers are paid on a fee-for-service basis. For certain high cost and restrictive services, such as psychiatric hospitalization, residential treatment and day treatment, prior authorization is required. For most services, authorization to a provider to provide services is simply based on a care coordinator's entering the requested services (based on the plan of care developed by the child and family team), units needed, and name of provider into the automated information system. Providers are immediately notified on-line of units of service approved for the upcoming month. The broad provider network is overseen by Wraparound Milwaukee's Quality Assurance Office.

## **► Finance Workforce Development Activities**

A variety of workforce development activities is financed in the sites.

### **AZ** **Arizona**

#### ***Financing Training and Coaching***

The state has used general revenue, block grant, tobacco funds, and federal State Infrastructure Grant (SIG) discretionary dollars to pay for training and coaching. Much of the training has focused on Arizona's vision and implementation of the 12 system of care principles, for example, partnering with families, implementing a child and family team (i.e., wraparound) approach, cultural competence, and the requirements of the reformed system of care. There also has been training related to particular subpopulations, such as children in child welfare and the 0-3 population.

The Arizona vision states: "In collaboration with the child and family and others, **Arizona** will provide accessible behavioral health services designed to aid children to achieve success in school, live with their families, and become stable and productive adults. Services will be tailored to the child and family and provided in the most appropriate setting, in a timely fashion and in accordance with best practices, while respecting the child's and family's cultural heritage."

The 12 Principles include:

- Collaboration with the child and family
- (Priority on) Functional outcomes

- Collaboration with others
- Accessible services
- Best practices
- Most appropriate setting
- Timeliness
- Services tailored to the child and family
- Stability
- Respect for the child’s and family’s cultural heritage
- Independence
- Connection to natural supports.

In the first year couple of years of implementation after the JK agreement, the state contracted directly for training and coaching. Beginning in the third year, it gave training dollars to the Regional Behavioral Health Authorities (RBHAs), and RBHAs have taken the lead in getting certain training curricula developed. For example, in Maricopa County, Value Options (VO) took the lead in developing 18 hours of pre-service training for foster parents wanting to be therapeutic foster parents. The state also has developed statewide training in a number of areas. For example, at the time of the site visit, the state had formed a workgroup with child welfare to develop training related to trauma and permanency, and was in the process of retaining a national consultant to help develop training curricula. The state also used the SIG grant to bring up telemedicine for a number of the tribes, identified substance abuse leads in each RBHA and sent them to a week of training, and sponsored a conference related to methadone maintenance. Also, child welfare training for new workers in the child welfare system includes training provided by the Family Involvement Center and VO on the child and family team process; at the time of the visit, the two systems were working on a more in-depth training.

Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/BHS) also indicated that it is looking at ways of trying to build stronger coaching and supervision into the behavioral health system to shore up training gains. This is a current priority.

## **HI** Hawaii

### ***Implementing a State-Level Practice Development Focus and Contracting with Universities***

The Child and Adolescent Mental Health Division (CAMHD) finances a Provider Relations Liaison position within CAMHD to serve as a communication linkage with providers and to promote positive relationships with CAMHD. The broad goal of the Provider Relations Liaison is to strengthen the relationship between CAMHD and its network of contracted providers. General Fund and Title IV-E resources are used to finance workforce development activities.

A Practice Development Section of CAMHD’s Clinical Services Office oversees a range of activities on evidence-based clinical practice and care coordination practice for CAMHD staff, contracted providers, staff of other state agencies, and families of children and youth with special needs. The section’s focus includes care coordination and provider practice in areas including evidence-based interventions, evidence-based practice components, core practice elements such as assessment and

engagement, measurement tools such as the Child and Adolescent Functional Assessment Scale (CAFAS) and the Child and Adolescent Level of Care Utilization System (CALOCUS), now known as the CASII (Child and Adolescent Service Intensity Instrument), etc. Practice development specialist positions are financed within CAMHD through general funds to provide consultation, training, and supervision to staff and contracted providers. Training on “parents as partners” is part of most training, and family members participate as trainers. Consultants are contracted to provide training as needed. Materials, training, supervision, consultation, practice guidelines, and other resources developed or identified by the Practice Development Section are disseminated to Family Guidance Centers, provider agencies, partner agencies, and families through courses, consultations, small group discussions, case reviews, conferences, or written materials. A Practice Development/Clinical Training Plan for 2006–2007 includes goals with objectives and specific strategies that will be implemented by practice development specialists and other CAMHD staff and consultants. Goals focus on supporting the implementation of evidence-based practices among clinicians; improving practice within CAMHD contracted residential programs; improving the transition to adulthood for CAMHD youth; improving planning for crisis prevention and intervention; identifying youth in need of intensive mental health services at younger ages; strengthening family involvement in treatment and in planning and policy throughout the system of care; implementing strong models of clinical supervision throughout the system; strengthening core components on children’s mental health in higher education curricula; developing a comprehensive system of care for youth with sexualized behavior; developing standards of practice for the CAMHD system; and developing policies, procedures, and plans that reflect clinical best practices and commitment to system of care principles.

Pre-service education is provided through significant contracts with the state university and small contracts with some private universities. Through these agreements, university faculty teach courses on systems of care, evidence-based practices, and other subjects critical to the public children’s mental health system. University faculty members also serve on various CAMHD committees. In addition, the contracts provide a mechanism for trainees across mental health disciplines to rotate through the children’s mental health system to obtain real life experience. Contracts range in size from under \$200,000 to about \$600,000. These contracts have been strategically used as mechanisms to shape university curricula to support the priorities and needs of the public children’s mental health system. An example of a contract with the University of Hawaii specifies that the University will:

- Collaborate on the development of opportunities for interdisciplinary seminars, lectures, and/or discussions when appropriate with the Schools including Psychiatry, Psychology, Social Work, and Nursing
- Provide interdisciplinary seminars and lectures on system of care principles and values, family-driven services, youth-guided services, cultural competency in mental health, evidence-based services (psychosocial interventions, prevention programs, and psychopharmacology), public child-serving systems (child welfare, education, mental health, and juvenile justice), community mental health, and core components of intensive clinical case management services
- Provide youth and family-led visits, discussions, and lectures
- Trainees shall attend and participate in the monthly Evidence-Based Services Committee
- Provide quarterly reports of services provided by trainees and progress with interdisciplinary lectures/seminars
- Participate in Case-Based Review training and observations

A contract with the University provides psychiatrists experienced in child and adolescent psychiatric services to provide clinical and administrative services within the state's Family Guidance Centers, youth correctional facility, and other sites, including medical and clinical supervision. In addition, the contracting mechanism is used to secure psychiatric residents to perform services in child and adolescent psychiatry in the Family Guidance Centers, including: diagnostic evaluations, ongoing psychiatric treatment, psychotherapy (individual, family, and group), prescribing and monitoring medications, maintaining medical records, consultation to provider agencies, educational seminars and case consultation to Family Guidance Center staff, mental health education to the community (including police departments), and research in community and cultural child psychiatry. Similarly, a contract with the University's School of Social Work provides trainees at the Master's level to work in the children's mental health system, and a contract provides graduate level psychology students to participate in CAMHD's evaluation activities. Doctoral level psychology students also are contracted to provide services in Family Guidance Centers. Another contract with the University establishes an Advance Practice Registered Nurse (APRN) program in child and adolescent mental health nursing for qualified students to prepare them to integrate with CAMHD's children's mental health system to provide services.

## **NJ** New Jersey

### ***Creating a Behavioral Research and Training Institute***

Financing for these activities is built into all aspects of the children's behavioral health system. Training and technical assistance are available to key staff at all levels and are ongoing. The state contracted with the University of Medicine and Dentistry of New Jersey to be the fiscal agent for training and technical assistance resources, and the University created the Behavioral Research and Training Institute to provide such services. Choosing this design allowed flexibility in using dollars to meet the technical assistance and training needs of staff. The state also has built in certain requirements for workforce development activities. All new staff has to go through training or orientation on the system of care, and the state also provided work specific training, e.g. all Care Management Organizations are trained to use the assessment and screening tool relevant to their job. **New Jersey** also has web-based certification in use of the Child and Adolescent Needs and Strengths (CANS) screening and assessment tools.

## **Choices** Choices

### ***Using Community Resource Managers and Training Coordinators***

Prior to contracting with providers to become part of the network, efforts are made to assess their competencies, as well as their values and beliefs regarding the care of children, family involvement, strengths-based practice, cultural issues, and the like to ensure consistency with **Choice's** philosophy and approach. The community resource managers provide training opportunities for providers in a variety of forms, including brown bag "lunch and learns." Quarterly forums are held with providers in the network to discuss themes, trends, the philosophy of care, the wraparound approach, and other topics to enhance their ability to work with children and families. Training topics may include cultural



competence, wraparound, the role and functioning of child and family teams, and others. Clusters of providers also may meet periodically for training purposes and to maintain positive provider relations. Additional support to providers is provided through Choice's care coordinators who are considered "ambassadors" to the providers and who consistently communicate Choice's philosophy and approach to care.

Choices has training coordinators in both Indiana and Ohio to provide in-house training to Choices staff. These coordinators, in collaboration with the site director, provide or arrange for 90-minute weekly training sessions that are mandatory for all staff. Attendance is taken at these trainings and participation in training is examined in performance reviews. New staff is provided with a checklist of required training and mentoring from veteran staff. Training is provided on TCM (The Clinical Manager management information system) and computer systems, as well as on the philosophy and process of providing individualized care. Though not fully developed as yet, Choices is working on developing "manuals" or written documents that detail its philosophy, service approach, and administrative processes.

Many Choices staff have Master's Degrees or obtained them while working. Universities often ask staff to return to the university and speak to graduate students. Professionals from Choices give presentations at various universities at least four or five times per semester. Topics include strengths-based care planning, what is wraparound, what is a system of care, etc. In addition, Choices provides placements for student interns in both Indiana and Ohio and often hire interns after they have completed their professional training programs.

Choices has a contract from the State of Indiana to operate a technical assistance center (TA Center) that provides training to other counties on the development and operation of systems of care. The current contract is for approximately \$402,000/per year and covers a director and three coaches. The TA Center works with all communities currently funded and many previously funded to build systems of care, as well as communities that have never received funding for this purpose. Communities may apply for a \$50,000 planning grant from the state; one of the TA Center's roles is to support them in the planning process to develop a viable, sustainable strategy to build a system of care. The participating communities have access to Choices database to assist in developing case rates, as well as to job descriptions and other structures and processes used by Choices that can be adapted in their respective communities. The TA Center has provided training and consultation to more than 60 of Indiana's 92 counties.

### **Wraparound Milwaukee** **Wraparound Milwaukee** ***Providing Training on the Wraparound Approach***

**Wraparound Milwaukee** provides training to providers in all aspects of the wraparound approach and Wraparound Milwaukee's operations. It also provides close supervision and coaching for care coordinators. Care coordinators must be certified by completing 40 hours of mandatory training, and there are mandatory, monthly in-service trainings on clinical and program issues. Wraparound Milwaukee partners with parent co-trainers and has a contract with Families United to provide training. It also has a contract with the child welfare system to train all 400 child welfare workers in the county on the wraparound approach and other elements of the program.

**AK Bethel, Alaska*****Creating a Health Education Center***

Yukon-Kuskokwim Health Corporation (YKHC) has a strong recruitment program for Native hires and a number of workforce development activities. Currently at YKHC, 71% of the staff is **Alaskan** Native or Native American. YKHC has a formal commitment to increasing this number and placing more tribal members in professional positions.

For the past year, YKHC has planned and developed a new Yukon-Kuskokwim Area Health Education Center (AHEC) in collaboration with the University of Alaska, Anchorage (UAA) School of Nursing and internal partners. YKHC's corporate training and development functions and current staff, formerly known as the Learning Center @ YKHC, will be incorporated into the YK AHEC. This new partnership provides an opportunity for YKHC to enhance staff development as well as sustain its Career Pathways program. AHECs create formal relationships between universities and community partners to strengthen the health workforce in underserved communities. They encourage youth in underserved areas to go to college and pursue a health career, encourage health professions students to go to work in underserved areas, and support continuing education opportunities for health professionals who are working in underserved areas.

The Rural Human Services Program is operated by a strategic partnership between the University of Alaska-Fairbanks and YKHC. The State of Alaska Department of Health and Human Services funds the program. Rural Human Services graduates and students deal with crisis situations; their strengths are enhanced by completion of the Rural Human Services program. They learn about resources available and the processes involved in their line of work.

Yuut Elitnaurviat or "The People's Learning Center" is another workforce development resource implemented through a partnership between YKHC, Lower Kuskokwim School District, the Association of Village Council Presidents, City of Bethel, Coastal Villages Region Fund, Bethel Native Corporation, AVCP Regional Housing Authority, and the Kuskokwim Campus of the University of Alaska at Fairbanks. These organizations have come together to construct a vocational training center that will focus on those in the 8th to 14th grades and lead them into career paths in the construction, health, education, and childhood development fields. The Learning Center is playing a key role in this project by developing the health careers curriculum and providing resources to the partnership in many ways.

## B. Providing Adequate Provider Rates

### **Strategies include:**

- Incorporating payment rates and policies that support and incentivize providers to develop and provide home and community-based services
- Incorporating payment rates and policies that are sufficient to recruit and retain qualified staff
- Incorporating mechanisms for providers to demonstrate the cost of care and request amended rates

### ► **Incorporate Payment Rates/Policies that Support and Incentivize Providers to Develop and Provide Home and Community-Based Services**

To create incentives for providers to develop and provide home and community-based services, **Arizona** set higher payment rates for services delivered in out-of-office settings. In addition, the rates paid for residential care decrease with longer stays to discourage inappropriate use of out-of-home care. Both **Choices** and **Wraparound Milwaukee** purchase primarily home and community-based services, in effect, creating a strong market for these services and incentives for providers to develop home and community-based service capacity.

#### **AZ** **Arizona**

##### ***Establishing Higher Rates for Services in Out-of-Office Settings***

The state established higher rates for out-of-office than for in-office services to encourage therapists to provide services in homes and schools and not just in offices. Also, it pays a tiered system of rates for out-of-home care, with rates decreasing with longer stays. In addition, there are multiple levels of case management provided by paraprofessionals, mental health techs and licensed professionals. The system pays the lowest rate to paraprofessionals in office-based settings and the highest rate to licensed professionals in out-of-office settings.

Value Options says that being able to be a provider in the network is an incentive to provide home and community-based services (since that is the thrust of the system reform). Also, the size and growth of the provider is contingent on the provider's performance in providing home and community-based services.

For out-of-home services, there is a tiered rate structure. The longer the length of stay in a level one placement (i.e., hospital or residential treatment center), the rate drops (with the exception of level one programs serving youth with sex offenses).

---

**Choices Choices*****Purchasing Primarily Home and Community-Based Services***

**Choices** purchases primarily home and community-based services; 80% of the dollars go to community providers. The rates paid by Choices are comparable to the rates paid by public sector agencies. Choices has, in effect, created new home and community-based services, such as mentoring. Its demand to purchase this service resulted in the establishment of a new “industry.”

**Wraparound Milwaukee Wraparound Milwaukee*****Purchasing Primarily Home and Community-Based Services***

Milwaukee’s entire orientation is toward home and community-based services. It has systematically conveyed that message to providers and has made clear the types of services it is most interested in buying. **Wraparound Milwaukee** developed definitions and rates for over 85 specific services and supports in its system. It sets its own rates for all of the services/supports in its network, except residential treatment, the rates for which are set by the state.

▶ **Incorporate Payment Rates/Policies that are Sufficient to Recruit and Retain Qualified Staff**

Payment rates and policies to help recruit and retain qualified staff were found in several sites.

**AZ Arizona*****Paying College Loans for Behavioral Health Professionals***

Arizona stakeholders reported that the system (as in many states) has difficulty recruiting and retaining staff. Legislation had been passed to pay off college loans of some professionals going into the behavioral health system, which Regional Behavioral Health Authorities (RBHAs) are using as an incentive for recruitment.

## **Choices** Choices

### ***Paying Usual and Customary Rates***

**Choices** pays providers their “usual and customary” fee, as documented in existing contracts for the service in question. Choices must pay rates that are comparable rates that providers receive for the service from other payers. The community resource manager has those average rates for particular services and then negotiates with individual providers and provider agencies. For new services, such as mentoring, Choices enters into negotiation with providers and establishes a new scale for payments. Small providers tend to get a greater share of Choices business. Larger provider agencies often are more demanding of higher rates, and, thus, may not receive the volume of referrals. The system is based on competition. Providers with favorable rates, and who consistently demonstrate positive outcomes, will receive the most consistent rate of referrals.

## **Wraparound Milwaukee** Wraparound Milwaukee

### ***Paying Providers Promptly***

Given the breadth of the Milwaukee network, the system pays rates that are sufficient to attract and retain providers. At the same time, **Wraparound Milwaukee** pays its providers very quickly, which is another incentive for providers to participate (and which can help to offset concerns about rate sufficiency). Providers are able to bill every week for services rendered, and they get paid within five days.

---

## VII. Financing for Accountability

Systems of care need reliable, practical data and accountability mechanisms to guide decision-making and quality improvement in the provision of services to children and adolescents and their families. The development of strong accountability and continuous quality improvement procedures requires investment in good information systems, as well as financing to support the collection, analysis, and use of data by administrators and other stakeholders to build on system strengths, remediate deficiencies, and make decisions about resource allocation. Accountability and quality improvement procedures require data on the population being served, service utilization, service quality, cost, and outcomes at multiple levels (the system level, service level, and child and family level). Use of performance-based or outcomes-based contracting allows systems of care to incorporate accountability procedures in contracts with providers. In addition, financing is required for a focal point of accountability for systems of care, that is, an agency, office, or entity that is responsible for policy and management of the system of care. Accountability procedures also should involve periodic assessment of financing policies and strategies to ensure their consistency and support for system of care goals.

### Specific Financing Strategies are:

- A. Incorporate Utilization, Quality, Cost, and Outcomes Management Mechanisms**
- B. Utilize Performance-Based or Outcomes-Based Contracting**
- C. Support Leadership, Policy, and Management Infrastructure for Systems of Care**
- D. Evaluate Financing Policies to Ensure that they Support and Promote System of Care Goals and Continuous Quality Improvement**

---

## A. Incorporate Utilization, Quality, Cost, and Outcomes Management Mechanisms

### *Strategies include:*

- Incorporating mechanisms to track and manage utilization, quality, cost, and outcomes
- Using data to guide financing and service delivery policies
- Using care managers to play a role in accountability
- Incorporating incentives or sanctions associated with utilization, quality, cost, or outcomes
- Financing the development of electronic medical records systems.

### ► Incorporate Mechanisms to Track and Manage Utilization, Quality, Cost and Outcomes

The sites studied make extensive use of mechanisms for tracking information related to service utilization, quality, cost, and outcomes and use this information for system improvement.

#### **AZ** Arizona

##### *Implementing a Quality Monitoring System Tied to Principles*

At the time of the study visit, **Arizona** Department of Health Services, Division of Behavioral Health Services (ADHS/BHS) was in the early stages of implementing a new quality monitoring (QM) system driven by the JK settlement agreement and is interested in using data to drive quality and effectiveness. In the past, quality monitoring was driven by Medicaid and focused on generic practice standards, such as access to care and physical/behavioral health coordination. Now, there is a QM children's subcommittee. The new quality system is tied to the 12 principles in the JK settlement agreement and includes both process and outcome measures. This includes a Child and Family Team Practice Review and reporting requirements related to outcomes.

Each Regional Behavioral Health Authority (RBHA) now undertakes an intensive review of the child and family team processes throughout its provider network. This is done through chart reviews and interviews with families conducted by independent teams of family members and wraparound specialists. This Practice Review is looking at process issues, not outcomes. In Maricopa County, 110 case reviews in one quarter were conducted. At the time of the visit, ADHS/BHS had just received the first round of data from RBHAs and will use the data to inform quality improvement efforts. For example, areas needing improvement identified by the first round of practice reviews included: a need for better use of natural helpers; a need for better crisis and safety plans; an issue with timeliness of service provision; and concerns about the adequacy of provider networks. Strengths included cultural competence and family involvement. As part of quality improvement, the Best Practices Committee is recommending a focus on supervisory-level training and coaching.



---

With respect to the new reporting requirements related to outcomes, for every child in the system, RBHAs are required to report outcomes in several areas — success in school; safety; preparation for adulthood; decreased criminal justice involvement; lives with family; and, increased stability in family and living conditions. There is a different set of outcomes for the 0–5 population, which include: emotional regulation, readiness to learn, safety and stability. Outcomes are reported by child and family teams at enrollment and at six months in response to “yes or no” questions, or by clinical liaisons for children who do not have a child and family team, who have to document a process involving children and families to answer the questions. These data can be found on the ADHS/BHS website under “What’s New: JK Measures.”

The system also tracks cost by funding source and cost by rate group (e.g., child welfare population) — there are 22 different funding categories. The cost data are broken out by child/youth and adult. These cost data are part of RBHA deliverables.

Arizona uses independent quality monitoring teams that include family members; also, there is a quality monitoring process mandated by Medicaid that involves independent case reviews of 1500 cases (adult and child) a year. ADHS/BHS also has access to 16,000 sets of data representing over 50,000 children and youth, and the data can be cut by age, ethnicity, region and whether a child has a child and family team, to support special analyses. Penetration rates of the child welfare population can be tracked and their use of out of home placements (but not of counseling services). Reportedly, the system is experiencing better outcomes for children who have child and family teams.

In terms of utilization management, this is a managed care system in which there are utilization management mechanisms at state, plan and program levels. Value Options monitors utilization in Maricopa County and pre-authorizes higher levels of care, such as residential treatment. Child and family teams manage utilization at an individual child/family level.

## **HI** Hawaii

### ***Implementing a Quality Assurance and Improvement Program***

The system has utilization, cost, quality and outcome data, managed by the Child and Adolescent Mental Health Management Information System (CAMHMIS) through its various modules. The Child and Adolescent Mental Health Division (CAMHD) has a Quality Assurance and Improvement Program (QAIP) operated by its central office and guided by a Performance Improvement Steering Committee. The types of data used to inform the quality improvement process include: utilization review, sentinel events, grievances and appeals, monitoring, caseloads and vacancies, access, credentialing, facility certifications, training, and other aspects of CAMHD’s performance. Each Family Guidance Center has an internal structure for reviewing performance data and managing performance improvement initiatives (an interdisciplinary Quality Assurance Team); a Quality Assurance Specialist at each Family Guidance Center manages these efforts.

---

In addition, each provider agency with which CAMHD contracts is required to have a continuous quality improvement system. Contractors are required to submit quarterly reports on the agency's Quality Assurance and Improvement Program. Providers also are required to submit the following quality data to CAMHD on a quarterly basis:

- **Access data** — number and percentage of referrals reviewed within 48 hours, number and percentage of youth accepted upon referral, number and percentage of youth seen within five days of referral, number and percentage of youth ejected from program
- **Quality of service provision measure** — number and percentage of staff fully credentialed
- **Least restrictive measure** — average length of treatment
- **Treatment measure** — number and percentage of youth that have met treatment goals

Outcome data are collected on each child served by CAMHD to enable evaluation of the performance of the system and its providers. Measures tracked include:

- Number and percentage of youth with improved functioning as measured by CAFAS or PE CAFAS, Achenbach and CALOCUS
- Number of youth served in an out of state setting
- Number and percentage of youth served within the community setting
- Number and percentage of youth with good school attendance
- Number and percentage of youth arrested
- Number and percentage of youth involved in school and community pro-social activities
- Satisfaction

An example of tracking quality is the quality review focused on the Coordinated Service Plans (CSPs). A number of indicators were identified and defined operationally regarding this individualized service planning process, resulting in a "review scale." The indicators specify that:

1. The plan includes all relevant stakeholders including the child and family as evidenced by signature and/or explanation.
2. The plan provides evidence that there is a clear understanding of what the child needs.
3. The plan is individualized and clearly identifies and links strategies to the preferences and strengths of the child, family and community.
4. There is evidence that informal/natural supports are indicated and infused into the plan.
5. Evidence-based strategies/interventions are included in the plan and are appropriate to the diagnosis.
6. Focal concerns and priority needs are addressed.
7. The plan conveys a long-term view that will lead the child toward desired goals and outcomes.
8. Services and strategies are accountable (includes persons responsible for implementation, timeliness, and resource provision.)
9. A contingency and crisis component is evident.
10. Transitions/discharges are adequately addressed.
11. If child is in an out-of-home placement, conditions and strategies for return home or appropriate least restrictive setting are clearly indicated.

---

CAMHD studied the rate of child improvements during fiscal years 2002–2004, including analyses across measures of functioning, service needs, and symptomatology. The study found youth were improving more rapidly at the end of the study than at the beginning. This time period coincided with performance improvement initiatives within CAMHD including the dissemination of evidence-based practices, improvement of care coordination practice, increased information feedback to stakeholders, improved utilization management, adoption of the use of statewide performance measures, restructuring quality improvement operations, and the integration of practice-focused performance management (i.e., quality assurance efforts that are discretely focused on specific practices, such as youth/family engagement, individualized planning, or coordination of services) at various levels of the service system. It was suggested that these system improvements may have an impact on improved youth outcomes.

The state routinely collects system performance information, including information on: the population served, service utilization data on the type and amount of direct services provided, financial information about the cost of services, system performance information about the quality and operation of the infrastructure that supports services, and outcome information regarding functioning and satisfaction of children, youth and families.

A statewide performance improvement committee reviews data and provides the data along with recommendations to the governing body. In addition, data are provided to the quality assurance (QA) teams at each of the Family Guidance Centers for review. Two Family Guidance Centers have emerged as being the most efficient while achieving the same outcomes as others. The state plans to study these centers to determine the strategies used by these centers to maintain both cost-efficiency and outcomes.

Utilization management efforts may suggest special studies that are then conducted in particular areas to focus on a systemic issue. For example, a study was conducted on utilization of therapeutic group homes to determine why utilization of this service was decreasing statewide. It was determined that schools did not refer youth to therapeutic group homes because there was no educational component. This led to identification of the need for an alternative school component to some therapeutic group homes to avoid placement in a residential treatment center.

A number of performance measures for the children’s mental health system operated by CAMHD are tracked to monitor the functioning of the system. For each of these performance measures, CAMHD has specified “statements” that break them down into specific indicators, thresholds for achievement, data to be used to derive the performance information, data source, and benchmarks.

1. CAMHD will maintain sufficient personnel to serve the eligible population
  - 95% of mental health care coordinator positions are filled
  - 90% of central administration positions are filled
  - Average care coordinator caseloads are in range of 15–20 per full time coordinator
2. CAMHD will maintain sufficient fiscal allocation to sustain service delivery.
  - Sustain within quarterly budget allocation
3. CAMHD will maintain timely payment to provider agencies.
  - 95% contracted providers are paid within 30 days
4. CAMHD will provide timely access to a full array of community-based services.
  - 98% of youth receive services within 30 days of request
  - 95% of youth receive the specific services identified by the educational team plan

5. CAMHD will timely and effectively respond to stakeholders' concerns.
  - 95% of youth served have no documented complaint received
  - 85% of provider agencies have no documented complaint received
  - 85% of provider agencies will have no documented complaint about CAMHD performance
6. Youth will receive the necessary treatment services in a community-based environment within the least restrictive setting.
  - 95% of youth receive treatment within the State of Hawaii
  - 65% of youth are able to receive treatment while living in their home
7. CAMHD will consistently implement an individualized client and family centered planning process.
  - 85% of youth have a current Coordinated Service Plan (CSP)
  - 85% of Coordinated Service Plan review indicators meet quality standards
8. There will be a statewide community-based infrastructure to ensure quality service delivery in all communities
9. Mental health services will be provided by an array of quality provider agencies.
  - 85% of performance indicators are met for each Family Guidance Center
  - 100% of complexes will maintain acceptable scoring on internal reviews
  - 100% of provider agencies are monitored annually
  - 85% of provider agencies are rated as performing at an acceptable level
10. CAMHD will demonstrate improvement in child status.
  - 60% of youth sampled show improvement in functioning since entering CAMHD as measured by the CAFAS or Achenbach
  - 85% of those with case-based reviews show acceptable child status
11. Families will be engaged as partners in the planning process.
  - 85% of families surveyed report satisfaction with CAMHD services
12. There will be state-level quality performance that ensures effective infrastructure to support the system.
  - 85% of CAMHD Central Office performance measures will be met

Data are used for system improvement. For example, data from the Annual Evaluation Report for fiscal year 2005 showed that disruptive behavior disorders comprised the most common problem among youth registered in the CAMHD system, with 48% having a primary or secondary diagnosis in the disruptive behavior category. Two evidence-based interventions with demonstrated effectiveness for youth with disruptive behaviors have been increased in the system — Multisystemic Therapy (MST) — (utilization increased in FY 2005) and Multidimensional Treatment Foster Care (an RFP for this service was recently released). In addition, the annual report showed that the growth in utilization of community residential services was contained, which was a system goal, although costs for this service increased. Data showed that evidence-based practices were not being used to the extent desired among CAMHD providers, prompting actions to increase their use in therapeutic interventions. Data also pointed to the need for further exploration of the factors that have resulted in youth being discharged from the CAMHD system with more problematic functioning and greater service needs than youth discharged in prior years, despite the fact that they showed improvement with services at a more rapid pace. Similarly, although out-of-state placements remained low, the report found an increase in the use of hospital services, suggesting the need for more aggressive strategies to reduce hospital utilization.

---

## **VT Vermont**

### ***Reporting State and Local Performance Information***

At local and state levels, the system of care incorporates a variety of utilization, quality, cost, and outcomes management mechanisms. Local agencies have a schedule of reported utilization and cost data to the state, and these are routinely reported. The state tracks:

- Quality of child behavioral health services
- Costs of child behavioral health services in total
- Costs of services by child served
- Outliers (i.e., high utilizers of services)
- Utilization and cost by type of population served

The state publishes many of these data in a statistical information resource from the Department of Mental Health and in periodic reports issued by the Vermont Performance Indicator Project, which issues brief reports on a weekly basis providing information about different aspects of the behavioral healthcare system (<http://healthvermont.gov/mh/docs/pips/pip-reports.aspx>). These reports (PIPs) are available on the state's website and investigate indicators such as:

- Access to care
- Practice patterns
- Treatment outcomes
- Concerns of criminal justice involvement
- Employment
- Hospitalization

These reviews often examine the relationship of mental health services with other programs and state agencies. Cross-agency data analysis is facilitated by the use of a statistical methodology that provides unduplicated counts of the number of individuals served by multiple agencies, without reference to personally identifying information, thus protecting confidentiality and complying with HIPAA.

In addition, the local Designated Agencies receive periodic reviews and a comprehensive review at least every four years to assure quality performance. Every two years, agency staff and members of the State Program Standing Committee conduct a separate program review as part of the State's continuous quality improvement plan. Detailed data are gathered on four quality domains: access to care; practice patterns of care; results of care; and agency structure/administration. The findings of this review form the basis for ongoing discussions and planning for program development, resource allocation, and budgeting. The state tracking and monitoring also has developed and relies on regular measurements of how caseloads overlap across agencies and on satisfaction with services by adolescents served and by parents of children served.

---

## **NE** Central Nebraska

### ***Tracking Utilization, Outcomes, Quality, and Costs***

**Tracking Utilization**—The cooperative agreement between the Nebraska Department of Health and Human Services and Region 3 Behavioral Health Services (BHS) to establish an individualized system of care for high need youth who are in state custody included a joint responsibility for utilization management. The Care Management Team (CMT), funded jointly by Region 3 BHS and the Central Area Office of Protection and Safety, serves this function. The CMT ensures that children/youth are cared for in the least restrictive, highest quality, and most appropriate level of care.

The Care Management Team (CMT) provides utilization management and review through a systematic process using the CAFAS, risk assessment tools, caregiver and youth interviews, psychological evaluations and other clinical and education/vocational information. It conducts pre-admission screening and ongoing review of children in higher levels of care. The CMT maintains an up-to-date database which tracks youth placement and monitors length-of-stay information. The CMT is staffed by licensed mental health clinicians. This is very helpful in the negotiations with Magellan for access to services for individual children. In FY 2005, 210 youth were referred to the CMT.

**Tracking Outcomes**—While families are receiving services, Professional Partners and Care Coordinators receive management information reports incorporating scores from the variety of assessment tools that are administered at intake and at regular intervals during service delivery. Integrated Care Coordination (ICCU) program directors are provided an executive summary which describes the children who have been accepted into an ICCU each month and the children who have been disenrolled. Areas tracked for accepted youth include: diagnosis, CAFAS scores, types of behavior displayed by the youth accepted, levels of care, assessment of parental behavioral health issues, each child's permanency plan, and status of adjudications. The report also summarizes the placement status for each child who is disenrolled.

**Tracking Quality**—The contract with Families CARE, the family support and advocacy organization in Central Nebraska, includes monitoring fidelity to the wraparound model. Families CARE staff collect information from parents, youth, and care coordinators to measure fidelity and to assess satisfaction. The results are aggregated and distributed to the various wraparound based programs. This feedback allows for continual improvements of the programs and builds capacity for parent-to-parent support by using family members as evaluators. Team members who participate on child and family teams are also asked to assess wraparound fidelity on a semi-annual basis.

**Tracking Costs**—To track utilization and account for how the Integrated Care Coordination (ICCU) program spends its case rate, Region 3 Behavioral Health Services (BHS) administrators prepare a monthly report that identifies, by child, direct service costs (including services provided, flex funds spent, and concrete expenditures such as transportation or rent) and non-direct service costs. This monthly report shows the extent to which the case rate was under — or over-spent for each child. From these reports on individual children/families, Region 3 BHS is able to track trends over a period of time such as: average cost per family, average cost of direct services, costs for youth who are in placement compared to costs for youth who are not in out-of-home placements, average monthly costs for different types of placements, and monthly associated non-service costs (including staff personnel costs). Yearly and monthly increases and decreases in expenditures by placement type also are tracked.



---

## **Choices** Choices

### ***Using an Integrated Management Information System***

An integrated management information system, called The Clinical Manager (TCM), was developed as a tool for system management in both the clinical and fiscal arenas. Encompassing all aspects of **Choices'** data requirements, TCM includes clinical information and plan of care, claims adjudication, service authorization, service utilization, tracking progress, tracking outcomes, tracking costs, medication management, historical information, and contract management. Clinical and fiscal records for a child and family can be viewed together, affording team members prompt access to both types of data and resulting in more efficient care management. Data are analyzed by: payers, team, and individual care coordinator. The Child and Adolescent Needs and Strengths (CANS), measuring clinical and family outcomes, has been integrated into the TCM process and is now a part of the software package.

Utilization is tracked based on service authorizations. Services are authorized prospectively and then authorization is compared with actual utilization. Monitoring utilization allows for an understanding of service utilization patterns, costs, and outcomes, and helps to identify team dynamics, training needs, provider management needs, and fiscal issues needing attention.

Choices contracted with the Indiana Consortium for Mental Health Services Research to conduct evaluation activities relative to Dawn in areas including profiles of Dawn Project participants, patterns of service use, the dynamics of the service coordination teams, client outcomes and service effectiveness, system-level functioning (the implementation of system of care principles within the managed care system), and the functioning of the family support and advocacy organization.

Recent evaluation data on Dawn demonstrated:

- Dawn was able to maintain the majority of its participants within community-based care settings.
- Ratings of functional impairments improved significantly as rated by the Child and Adolescent Functional Assessment Scale (CAFAS), Child Behavior Checklist (CBCL), and Behavioral and Emotional Rating Scale (BERS)
- Number of delinquent offenses committed by youth in Dawn declined over time
- Youth showed significant improvement over time in school attendance, level of discipline problems, and academic performance
- 65% of youth leave the program by meeting goals established by their child and family team
- Majority of caregivers (and youth) are either satisfied or very satisfied with services provided, level of cultural competence, and their level of involvement in planning treatment
- Caregivers reported significant improvement in their overall functioning and perceived level of caregiver strain
- Dawn provides a diverse mix of services.
- Two services most closely related to less positive outcomes and increased expenditures are crisis/respite and residential treatment services
- Dawn increased collaboration among child-serving systems in Marion County, highlighted importance of family involvement, and drew attention to family strengths as the basis of treatment planning.



---

## **Wraparound Milwaukee** **Wraparound Milwaukee**

### ***Using a Web-Based Management Information System***

**Wraparound Milwaukee** is a data-driven system that is supported by Synthesis, a web-based management information system, built and owned by Wraparound Milwaukee. Synthesis allows the system to capture real time, as well as retrospective, data. For example, progress notes on individual children are automated through Synthesis so that the MIS system is used, not only by managers and policymakers, but by clinicians and care managers. Synthesis captures all care planning, crisis plans, safety plans, and progress notes. It tracks all services/supports provided, for which youngsters and at what cost. It captures demographic data and outcome data. It is used for billing and claims adjudication and links to a system for automatic check writing. Providers are able to bill every week for services rendered, and they get paid within five days. Synthesis data also are used by Wraparound Milwaukee's quality improvement (QI) staff. Over 300 people use Synthesis; Milwaukee uses a "train the trainers" approach to build capacity to use Synthesis.

Wraparound Milwaukee tracks program, clinical, fiscal, system and safety outcomes. It addresses the following:

- Is there improved clinical functioning as measured by the Child and Adolescent Functional Assessment Scale (CAFAS)? (Note: Wraparound Milwaukee is considering abandoning use of the CAFAS, perhaps moving to use of the Child and Adolescent Needs and Strengths (CANS).
- Has there been a reduction in the restrictiveness of living environment?
- Is there a reduction in juvenile justice contacts?
- Has school attendance improved?
- Are the wraparound costs comparable to or less than residential treatment costs?
- Are families and youth satisfied with services?

In terms of utilization management, this is a managed care system, in effect, in which there are utilization management mechanisms at the care coordinator and system management levels. Certain high-cost services, such as residential treatment and inpatient hospitalization, may require prior authorization, and outliers are reviewed. However, most providers are notified of units of services approved for the upcoming month, based on the plans of care and service authorization requests submitted by care coordinators. Providers invoice online, and Synthesis matches services provided with those authorized under the plan of care.

---

## ► Use Care Managers to Play a Role in Utilization, Quality, Cost, and/or Outcomes Management

Care managers play important roles in managing utilization, quality, cost, and outcomes in the sites. **Arizona, Hawaii,** and **Wraparound Milwaukee** provide data on a regular basis to care managers to monitor their assigned children and families and to enable them to compare their practice patterns with those of other care managers. **Choices** provides data to child and family teams, team leaders, and care managers enabling them to assess their approaches, costs, and outcomes and to make appropriate adjustments.

### **AZ** Arizona, **HI** Hawaii, and

### **Wraparound Milwaukee** Wraparound Milwaukee

#### ***Providing Data to Care Managers***

- In **Arizona**, Child and Family Team facilitators must ensure that child and family teams review all outcome domains at least every six months.
- In **Hawaii**, care managers facilitate the child and family team process. The Coordinated Service Plan developed by the child and family team serves as the mechanism for service authorization, as all services and supports included in the plan are considered to be authorized. Care managers receive data reports on their practice, documenting services they are authorizing through the child and family team process and comparing their service utilization patterns with those of other care managers and with statewide patterns.
- In **Wraparound Milwaukee**, care coordinators and child and family teams have a responsibility to monitor outcomes and costs for individual children and families.

### **Choices** Choices

#### ***Providing Data to Child and Family Teams, Team Leaders, and Care Managers***

Child and family teams can review and respond to trends in service provision and cost data among the population assigned to their team, enabling them to assess their approach more globally and plan their service strategies. The management information system (The Clinical Case Manager or TCM) helps to link process, outcome, service utilization, and cost data in a way that assists Choices to assess what services work, in what ways, for which children, and at what cost. Data reports are produced by worker and by team so that team leaders can review how workers use particular services and trends of teams. Inquiries focus on: (1) number of children in out-of-home placements, (2) types of out-of-home placements used, (3) four-month trends regarding out-of-home placements, (4) overall cost per child, and (5) mentoring costs.

---

## ► Incorporate Incentives or Sanctions Associated with Utilization, Quality, and/or Cost Management

In **Arizona**, incentives are included in contracts with Regional Behavioral Health Authorities related to standards for access, functional improvement, satisfaction, consumer and family involvement, and others. In other sites (**Hawaii, Vermont, Choices**, and **Wraparound Milwaukee**), sanctions primarily involve discontinuing the participation of the provider if appropriate corrective actions are not taken in response to identified problems associated with utilization, quality, cost, or outcomes.

### **AZ** Arizona *Using Incentives*

Contract requirements with the Regional Behavioral Health Authorities (RBHAs), to which incentives are attached, relate to: access standards; measurement of functional improvement; consumer and family satisfaction; coordination of care; cultural competence; and consumer and family involvement. These are also the measures used for quality improvement. The incentive pool represents 1% of the entire capitation pool. If RBHAs meet performance standards, they may receive funding from the incentive pool.

### **HI** Hawaii, **VT** Vermont, **Choices** Choices, and **Wraparound Milwaukee** Wraparound Milwaukee *Using Sanctions*

- In **Hawaii**, referrals to a provider agency may be stopped if there are concerns about utilization, quality or cost. Typically, data highlighting problems with utilization, quality, or cost are shared with the agency and corrective action is requested. In some cases, a provider agency may be closed for continued substandard performance. First, admissions at the agency could be closed for a period of time; then children could be moved to other providers and the agency closed temporarily; then, the agency could be closed permanently. This has occurred once over the past six months.
- In **Vermont**, the process of agency reviews results in a rating that indicates quality performance, may identify areas for improvement that are detailed in a corrective action plan, or begin a process to cut the agency from the contractor network because it failed to meet standards.
- In **Choices**, sanctions available for providers involve primarily declining to make new referrals based on feedback from families and staff. Providers receive feedback from the community resource manager.
- In **Wraparound Milwaukee**, the system has an incentive to pay attention to cost and quality issues among providers, since the bulk of its funding is risk-based (either capitation or case rates). Providers are paid on a fee-for-service basis, and Wraparound Milwaukee monitors their performance closely. If a given provider is not providing the types of services or quality care the system wants, it will not be used. Wraparound Milwaukee believes that its use of a “qualified provider panel,” from which providers are paid on a fee-for-service basis if they are used, gives it the mechanism to better manage quality and cost of care provided.

---

## B. Utilize Performance-Based or Outcomes-Based Contracting

### ► Use Performance or Outcomes-Based Contracting

Performance or outcomes-based contracting is not utilized widely in the sites studied. However, some of the sites are working towards implementing performance-based contracting.

#### **AZ** Arizona

##### ***Using Performance Standards in Contracts with Regional Behavioral Health Authorities***

The **Arizona** Department of Health Services, Division of Behavioral Health Services' (ADHS/ BHS) contracts with Regional Behavioral Health Authorities (RBHAs) include penalties for poor performance, but the state is interested in pay for performance arrangements in the future. The state does allot extra funds to plans that meet access to care standards. Value Options (VO) reported that they met the standards to receive the extra funding and then had to decide how to allocate the monies to providers in the network. None of the providers met all standards, but some met several of them so VO decided to give funds to all of the providers who met at least one standard.

VO also indicated that it has implemented both incentives and sanctions for Comprehensive Service Providers related to access for the Latino population. Providers can receive up to \$10,000 a month depending on their meeting certain access standards (e.g., \$2500 per month if reaching 40% of Latino eligibles).

#### **Choices** Choices

##### ***Developing a "Score Card" for Provider Outcomes***

**Choices** is working to develop a "score card" which would provide indicators for providers regarding the outcomes of particular services by provider. One aspect of this would involve tying Child and Adolescent Needs and Strengths (CANS) data to providers to assess whether behavior is improving with a service, such as individual therapy.

---

## C. Support Leadership, Policy and Management Infrastructure for Systems of Care

**Strategies include:**

- Supporting a focal point for policy and management of systems of care
- Financing leadership development activities for systems of care

### ► Finance a Focal Point for Policy and Management of Systems of Care and for Identified System of Care Leaders

All of the sites finance some type of focal point for management of the system of care. In most cases, this involves a state-level focal point of responsibility, as well as a local agency or entity for local system management.

#### **AZ** Arizona, **HI** Hawaii, **NJ** New Jersey, **VT** Vermont, **NE** Central Nebraska, **Choices** Choices, and **Wraparound Milwaukee** Wraparound Milwaukee **Financing a Focal Point for System of Care Management**

- In **Arizona**, state-level leadership is provided by Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/BHS) in partnership with its sister agencies. Leadership for the system at the county level in Maricopa County is provided by the Regional Behavioral Health Authority (at the time of the site visit, this was Value Options) and the Family Involvement Center, working with other child-serving systems and stakeholders on an ad hoc basis.
- In **Hawaii**, the Child and Adolescent Mental Health Division (CAMHD), within the Department of Health, serves as the focal point for system management for the public children’s mental health system. A governing body oversees all policy making and management related to systems of care; this body does not involve cross-agency representation. The governing body is comprised of the CAMHD Division Chief, Medical Director, Performance Manager, the Executive Director of Hawaii Families As Allies, Branch Chiefs, and the Provider Relations Specialist. An interagency quality assurance committee plays a monitoring and advisory role to the system. Community interagency quality assurance committees play a similar role at the local level. Leaders for systems of care are positions within CAMHD at the state level, and within Family Guidance Centers at the local level.
- In **New Jersey**, the Division of Child Behavioral Health Services, Department of Children and Families, is the focal point for management of the statewide system of care initiative. The state contracts with an ASO-type entity (the Contracted Systems Administrator) to coordinate, authorize, and track care for all children entering the system and to assist in managing the system

---

of care and improving quality. Locally, a Care Management Organization (CMO) in each region provides care coordination and accountability for children with intensive service needs. The CMO partners with a Family Support Organization (FSO) whose role is to provide education, support, and advocacy for caregivers and family members of children with serious emotional problems.

- In **Vermont**, the Department of Mental Health is the lead state office for children’s mental health. Vermont’s system of care legislation (Act 264) identifies agency partners and their responsibilities, as well as the fundamental partnership with families. A lead agency (Designated Agency) in each region is responsible for local management and operation. These structures are supported by local interagency teams and a state interagency team, which provide technical assistance and consultation on individual cases and a vehicle for problem-solving on systemic issues. The system level work is enhanced by a state level Advisory Board whose nine members are appointed by the Governor to advise the stakeholders on annual priority recommendations to further improve the interagency system of care.
- In **Central Nebraska**, when a federal grant was received in 1997, the system of care was based on an existing infrastructure. Region 3 Behavioral Health Services (BHS) is the entity with a statutory responsibility to administer behavioral health services in Central Nebraska. This greatly enhanced the chances for sustainability. A cooperative agreement exists between the Nebraska Department of Health and Human Services (DHHS) and Region 3 BHS to create an individualized system of care for children in state custody who have extensive behavioral health needs. Within Central Nebraska, the system of care is managed as a “three legged stool” including Region 3 BHS (behavioral health) the Nebraska DHHS Central Service Area Office of Protection and Safety (child welfare) and Families CARE (family support and advocacy organization).
- **Choices** is the focal point for system management for high-need youth in Marion County, Indiana; Hamilton County, Ohio; and Montgomery County and Baltimore City, Maryland.
- **Milwaukee** has created a focal point for the management of high-need youth through Wraparound Milwaukee, which is financed through multiple cross-system funding streams.

## ► Finance Leadership Development for Systems of Care

The sites have implemented strategies to finance leadership development and training for systems of care.

### **AZ** Arizona

#### ***Financing Leadership Development and Training***

The state has used tobacco monies, discretionary and formula grant funds to support leadership development across stakeholder groups (such as children’s systems, families, providers, and BHOs) in support of the JK settlement agreement.

---

## **HI** Hawaii

### ***Operating a State-Sponsored Leadership Development Program***

A ten-week leadership development program was sponsored by the state agency within the last year, focusing on both the theory and practice of leadership. The comprehensive leadership development course involved a full day of participation each week for the duration of the program. Families from **Hawaii** Families As Allies participated along with mental health system representatives including branch chiefs and one level below branch chiefs throughout the agency. The goal was to create “empowered teams” throughout the system.

## **NE** Central Nebraska

### ***Using Federally Funded System of Care to Provide Technical Assistance***

The state has assumed a leadership role in developing systems of care across the six regions in **Nebraska**. Once Region 3 began to show positive results and a cost savings, its system of care leaders were encouraged by the Nebraska Department of Health and Human Services (DHHS) to provide technical assistance to other regions/service areas to implement similar systems. Five of the six regions in Nebraska now have a care coordination system in place for children with significant mental health needs. One of the regions (Lincoln) also benefited from a federal system of care grant. However, the other three regions have implemented systems of care with some additional DHHS funding and the technical assistance provided with Region 3 cost savings.

## **Choices** Choices

### ***Creating a State-Funded Technical Assistance Center for Systems of Care***

**Choices** has been a key technical assistance resource for other areas of Indiana working to develop systems of care. In 2002, Choices was officially funded by the state as a technical assistance center (Technical Assistance Center for Systems of Care and Evidence-Based Practice) to provide assistance in developing systems of care throughout the state. The training and coaching provided through this center has been an important strategy for developing knowledgeable and skilled leaders for systems of care in Indiana.

## **Wraparound Milwaukee** Wraparound Milwaukee

### ***Providing Training in System of Care Principles and Operations***

Through its funding of Families United, training of providers, and staff development in system of care principles and operations, **Wraparound Milwaukee** is creating leaders among stakeholder groups, for example among care coordinators, family members, judges, and others.



---

## D. Evaluate Financing Policies to Ensure that They Support and Promote System of Care Goals and Continuous Quality Improvement

### *Strategies include:*

- Assessing financing policies and strategies to ensure that they promote system of care goals and continuous quality improvement
- Collecting and using cost-benefit data

### ▶ Assess Financing Policies and Strategies for Promotion of System of Care Goals and Continuous Quality Improvement

Measurement of progress toward the financing goals established in *Hawaii's* strategic plan provides a framework for the periodic assessment of financing strategies and their effectiveness in achieving system of care goals.

#### **HI** Hawaii

##### ***Using Strategic Plan Goals and Progress Assessment***

The new strategic plan specifies financing policies and strategies to promote the system's goals. This has set the stage for assessment of the effectiveness of these financing strategies during the course of implementing the strategic plan for the next period. In addition, cost is examined as a part of assessing quality. Financial targets are set by the system, and financial reports are reviewed as a component of performance monitoring

---

## ► Collect and Use Cost-Benefit Data

**Hawaii** collects and uses cost-benefit data through a process referred to as Data Envelope Analysis (DEA). **Wraparound Milwaukee** collects and uses data on cost savings for youth who would otherwise be in residential treatment or correctional facilities.

### **HI** Hawaii

#### ***Collecting and Using Cost-Benefit Data from Data Envelope Analysis (DEA)***

Cost-benefit data is used by the system. Information from Data Envelope Analysis (DEA) analyses is provided to the governing body. DEA is a linear programming methodology that examines the relative efficiencies of six mental health centers (Family Guidance Centers). The methodology is considered to be an important decision support tool for focusing quality and financial improvement efforts within a mental health service delivery system. The method involves examining multiple resource inputs (such as costs of operating expenses, staffing patterns, etc.) along with multiple quality outputs (such as youth outcomes, quantity of services, etc.). These multiple input and disparate input and output (cost and quality) measures are converted to a single comprehensive measure of “efficiency.” In an example of the application of this methodology, indicators of quality outputs were compiled from the Child and Adolescent Mental Health Division’s (CAMHD) usual performance monitoring reports. Quality indicators included the percentage of youth receiving intensive in-home services not removed from their homes, percentage of youth with Coordinated Service Plans meeting quality standards, percentage of youth showing improvement on the Child and Adolescent Functional Assessment Scale (CAFAS) or Achenbach System for Empirically Based Assessment, and percentage of youth with no documented complaint or grievance. Input indicators were taken from CAMHD’s routine staffing and financial summary reports and included office expenses per average client day per month, salary expenses per average client day per month, number of full time equivalents of care coordinators per average client day per month, selected summary costs of therapeutic services per average client day per month, and selected costs of out-of-home treatment services per average client day per month. The results showed that five of the mental health centers could be considered “efficient,” but one of the six mental health centers had the lowest percentage of clients showing improvement on the CAFAS or Achenbach System for Empirically Based Assessment, as well as the highest input of resources per client day for three of the five resource inputs. The application of the DEA methodology allowed managers to compare themselves to those with the lowest costs and highest outputs. The analysis also indicated the need for additional data or operational evaluations to clarify results.

---

## **Wraparound Milwaukee** **Wraparound Milwaukee**

### ***Collecting and Using Data on Cost Savings***

Milwaukee does not have cost/benefit data per se, but it does have data available showing the cost savings for youth who would otherwise be in residential treatment or correctional placements and for children in child welfare who are in more permanent living arrangements. **Wraparound Milwaukee** contracts for a full-time evaluator who can conduct analyses using data directly from the Synthesis management information system. The system also has a strong quality improvement infrastructure.

Wraparound Milwaukee outcomes include the following:

- Decrease in daily residential treatment center (RTC) population from 375 to 50
- Reduction in psychiatric inpatient days from 5,000 days to less than 200 days per year
- Average monthly cost of \$4,200 (compared to \$7,200 for RTC, \$6,000 for juvenile detention, \$18,000 for psychiatric hospitalization)
- 60% reduction in recidivism rates for delinquent youth from one year prior to enrollment to one year post enrollment
- School attendance for child welfare-involved children improved from 71% of days attended to 86% days attended
- Reduction in placement disruption rates in child welfare from 65% to 30%
- 91% of families reported that they and their child were treated with respect
- 91% of families reported that staff were sensitive to their cultural, ethnic and spiritual needs

## VIII. Financing Strategies for Tribal Systems of Care

Financing systems of care and their component services is particularly challenging in tribal communities. The complications that arise when attempting to coordinate across multiple jurisdictions (for example, multiple states, tribal governments, the Indian Health Service, etc.) are complex and difficult to navigate. Systems of care in tribal communities may differ significantly from other systems of care in that they must fit within the reality of the multiple jurisdictions and bureaucracies that affect them. Strong leadership, coupled with political and policy support, are critical factors in developing and implementing effective financing strategies for tribal systems of care. In addition, system of care development in tribal communities occurs in the context of historical trauma and in the context of a non-Western view of mental health problems and treatment. Thus, application of the system of care approach must be adapted to consider the conceptualization of illness and traditional healing approaches found in Native American communities. Effective financing strategies in tribal communities involve collaboration among states and tribes, as well as coordination of federal, state, local, and tribal financing streams.

### Finance Tribal Systems of Care Through Collaboration Among States and Tribes and Coordination of Federal, State, Local, and Tribal Financing Streams

**Arizona** and **Bethel, Alaska** provide examples of effective financing strategies for tribal systems of care. In Arizona, Tribal Regional Behavioral Health Authorities (TRBHAs) operate within the state's managed care system and may serve any tribal member. In Bethel, Alaska, a tribal organization (the Yukon-Kuskokwim Health Corporation [YKHC]) administers a comprehensive health care delivery system for the 56 rural communities comprising this area. Both approaches involve collaboration between the state and tribes, coupled with coordination of multiple federal, state, local, and tribal financing streams.

#### **AZ** Arizona

##### ***Using Tribal Regional Behavioral Health Authorities (TRBHAs)***

Only two of **Arizona's** 21 tribes opted to provide their own behavioral health services as Tribal Regional Behavioral Health Authorities (TRBHAs) through the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/BHS) managed care system. The TRBHAs may serve any tribal member; that is, they are not restricted by geography or particular tribal affiliation, which is one of the reasons that the TRBHAs are not capitated. Tribal members also may receive services through the Indian Health Service (IHS). Native Americans who live off the reservation, and are tribal members of a community that operates a TRBHA, can choose to enroll in the community's TRBHA or enroll in the regular RBHA in their geographic area.

Those tribes that chose to set up a TRBHA typically had the infrastructure and revenue from casinos and were already making good investments in tribal health care. They saw the TRBHA as a means to maximize their ability to use Medicaid and improve access to and coordination of services. Health and behavioral health services provided by Indian-run facilities are eligible for 100% federal Medicaid contribution, known as the federal pass-through program. In effect, Arizona tribes must deal with a bifurcated Medicaid system — the 1115 waiver in the state and the federal pass-through for tribes. The federal pass-through benefit is more traditional than the array of services covered under the 1115 waiver, but the federal rate ends up being higher than state rates, and there is 100% federal funding. For example, case management is not a covered service by the pass-through, but it can be paid for through the 1115 waiver. The TRBHA will “pick and choose” whether to bill the federal pass-through or the 1115 waiver. The federal pass-through can only be used for services directly provided by the tribe. There are over 60 providers — adult and child — in the Gila River TRBHA network. Only those that are Gila River community providers can be billed through the federal pass-through; the off-reservation providers are billed through the 1115 waiver. The Gila River TRBHA is actively looking at how to integrate TRBHA and IHS behavioral health services.

An issue for the TRBHAs is that, unlike the RBHAs, they must use the state rates for services since they are not capitated. (The RBHAs may establish their own rates within broader State guidelines.) So, reportedly, Value Options in Maricopa pays higher rates for some services in short supply, such as therapeutic foster care, which aggravates the Gila River TRBHA's ability to expand capacity. This also affects utilization since home and community-based alternatives are in short supply and, thus, more restrictive services end up being used. One example provided by the Gila River TRBHA was the rate paid for sub-acute care. Value Options' rate was \$595/day, compared to the state rate, which was \$240/day. Reportedly, the rate was increased by the state to \$700/day, and ADHS/BHS is looking at increasing the state rate for therapeutic foster care as well.

The Gila River TRBHA indicated that it started with the basics – crisis services and counseling services in home and at schools. It is now moving to more home and community-based services, such as family support. It is recruiting family members as peer support providers (paying \$9-13/hour); since job opportunities are very scarce on the reservation, they feel they will not have difficulty recruiting.

The Indian Health Service (IHS) behavioral health clinic was not part of the TRBHA network at the time of the site visit. The IHS clinic was described as having long waiting lists and as referring to the TRBHA. The TRBHA would like to move this clinic into their network, which would also allow them to manage the quality of care. IHS also operates a drug and alcohol program at Gila River, and the tribe is building a residential substance abuse program. These services also are outside of the TRBHA network at present. (Since the site visit, the TRBHA has made progress and the IHS behavioral health clinic is in the process now of enrolling in the TRBHA network, and the residential substance abuse facility will become part of the TRBHA network once the facility is open.)

The Gila River TRBHA indicated that it does not have the infrastructure to be capitated and that it is trying to work around problems created by rates and lack of capacity on an ad hoc basis, rather than seeking capitation. For example, it contracts with Value Options to be able to refer youth to Value Option's walk-in urgent care centers.

RBHAs are required contractually to have specialized Native American providers in their networks. In Maricopa County, there is reportedly one (off reservation) provider that specializes in serving Native American youth. There is some overlap between populations served by Value Options and Gila River. The Gila River TRBHA serves about 400 youth, about a 15–17% penetration rate, which they describe as low penetration given the need, although they also noted that they have the

highest penetration rate in the state. (As noted earlier, the statewide average penetration rate for the Medicaid/S-CHIP population is about 10%–12%. Also, since the site visit, the TRBHA penetration rate reportedly has increased to 21%.) Self-referral is the leading referral source, with the Indian behavioral health clinic, the schools, juvenile justice and Indian child welfare also referring youth. Reportedly, the percentage of tribal youth in out-of-home care is higher than with other populations of youth because of the lack of alternatives. However, the number also reportedly is decreasing with use of the child and family team approach. Community buy-in remains an issue, however, to keeping youth at home. The Gila River TRBHA reported good relations with Tribal social services and with juvenile justice. Indian child welfare does not have its own dollars for behavioral health services so it looks to the TRBHA as a resource. They collaborated to develop a therapeutic foster home, with Indian child welfare covering room and board. There is not, however, a strong interagency policy group for the tribe, and services are described as very compartmentalized. There is, however, increasing recognition of the potential of the TRBHA.

The TRBHA describes the child and family team (CFT) process as a “good fit” with the values in the community. Case management caseloads, which were running very high (1:50–60), are now down to about 1:38 as a result of ADHS/BHS providing additional funds to the TRBHA (about \$250,000). The TRBHA also is getting some State Infrastructure Grant (SIG) dollars for training in CFT implementation, will get a half-time coach, and dollars for telemedicine and video conferencing from the state. The TRBHA is implementing mentoring, peer supports for families and use of stipends for family partnership. There is a parent group, called Purple Onions, which at the time of the site visit was not interfacing with FIC or MIKID (recently, these organizations have begun to provide technical assistance to Purple Onions). The TRBHA indicated that it can incorporate Native traditions, such as traditional Native healers, by using general revenue state dollars (not Medicaid).

Since the time of the site visit, the TRBHA has moved more to a “staff model” of owning its own services and clinical staff, rather than exclusively contracting out for services. For example, it has implemented an intensive outpatient program (IOP) for women recovering from methamphetamine use that it operates directly and has hired its own in-home therapist so that it does not have to rely solely on county providers. The TRBHA also has hired an after care therapist for substance abuse services. Most of this new service capacity has been made possible with funding from the state (ADHS/BHS). The TRBHA believes that this approach will accomplish several goals: a higher degree of culturally relevant care; easier access to care; greater continuity and coordination of care between therapists and case managers (who are employed by the TRBHA); and, generation of revenue from the staff model (i.e., through Medicaid billings) that can be used to expand services. The state does prior authorization for all out of home placements for the TRBHA, but the TRBHA indicated that this is not an adversarial process.

## **AK** Bethel, Alaska *Using a Tribal Health Corporation*

At the state level, **Alaska** has been a national leader in collaboration among tribes, tribal health programs, Indian Health Services, and the Alaska Department of Health and Social Services. Collaboration between the state and tribes is demonstrated by joint work around Medicaid and S-CHIP. The Medicaid authority has dedicated staff at the state level for administration of the Tribal Health System. Further, a State/Tribal Medicaid Task Force was implemented that, among other functions, was responsible for the design of Alaska's S-CHIP program and development of a uniform set of billing policies. Agreements are in place between Medicaid and Tribal Authorities, and a Tribal billing manual has been produced.

A reorganization of services to Tribes (referred to as "638 compacting") began in the mid-1960s and resulted in the 1994 All Alaska Tribal Compact. Under the statewide compact, the Tribal organizations took over the operations of health care facilities formerly operated by the Indian Health Service (IHS), as well as certain centralized services. Each of the Tribal organizations negotiates a funding agreement with the IHS annually, although federal IHS funding is available for only 40% of the need for health care services. Today, 12 regional Tribal health corporations administer 7 hospitals, 28 clinics, and 176 village clinics. The Tribal corporations are the sole health and behavioral health provider in most areas, and the state is dependent on these Tribal health providers to offer a variety of programs and services. The Tribal corporations are funded by state grants, Medicaid, Indian Health Service, and federal grants. One hundred per cent of costs for dental, health, mental health, and substance abuse services for Medicaid eligible individuals are reimbursed to the Tribes by Medicaid funds. Medicaid administration and training related costs are matched at the 50% federal match level.

Operational costs of the health care corporations are high, due to the challenges of offering services in vast remote areas, difficult transportation challenges, harsh weather, and constant workforce shortages.

Health and behavioral health services in the region are the responsibility of the Yukon-Kuskokwim Health Corporation (YKHC), a tribal organization which administers a comprehensive health care delivery system for the 56 rural communities in southwest Alaska. YKHC has put extensive resources into the building and development of village health clinics offering both health and behavioral health services. In addition to the community health clinics in the villages, the system includes four sub-regional clinics, a regional hospital, dental services, behavioral health services including substance abuse counseling and treatment, health promotion and disease prevention programs, and environmental health services. The programmatic approach for children's mental health services was adopted with a federal system of care grant and is comprised of core teams of licensed mental health professionals and behavioral health aides that are responsible for service delivery in the rural villages of the Delta area. Behavioral health aides are indigenous practitioners specially trained to provide behavioral health services to individuals living in the widely scattered villages in Alaska. The core service teams were developed and organized around the existing four sub-regional clinics and currently include an itinerant clinician and behavioral health aides. The core teams are financed by Alaska's Medicaid authority in the Department of Health and Human Services, Tribes, Tribal health programs, and the Indian Health Service.

To illustrate, the clinician who covers Upper Kalskag lives in Aniak (the sub-regional clinic location) and is responsible for 15 villages and five behavioral health aides. She flies from village to village three to four days a week. The clinician's supervisor is located in Bethel. The child protection



office for Upper Kalskag is also located in Aniak. The child welfare system has a worker who gets involved with families where child abuse has occurred and makes referrals to the behavioral health aide for both children and parents. The referral is often for substance abuse issues, but the clinician and behavioral health aide look at the whole person and family. The clinician has a small caseload in Aniak. Typically, she sees people once in the villages as part of the assessment to make a diagnosis; she is not the primary counselor except when there are complex family issues. Services are provided by behavioral health aides receiving supervision from the clinician.

Emergency on-call mental health services are operated from Bethel. Emergency Services clinicians and complex care managers are available 24 hours a day to respond to behavioral health crises. The clinicians are master's level with both experience and specialized training in mental health and substance abuse treatment. The complex care managers are experienced counselors whose specialty area is working in the field of substance abuse treatment. If there is a crisis, the crisis person in Bethel talks with the behavioral health aide about what to do. The crisis counselor sometimes provides crisis intervention counseling by telephone.

Behavioral health aides typically have strong partnerships with schools. Coordination of funding at the village level primarily takes place with the school district. For example, a request for a neurological assessment may be on a child's individual education plan (IEP). If the request is on the IEP, the school district pays for the assessment. If the request is not on the IEP, the request would be referred to a physician and a medical facility; Medicaid would likely be the payer.

YKHC sponsors several projects that are designed to offer and support culturally competent services and supports. The Family Spirit Project, for example, is a collaborative effort of the communities of the Yukon-Kuskokwim region, the Department of Health and Social Services, Division of Alcohol and Drug Abuse, Office of Children's Services, the YKHC, and others. Emphasizing traditional family life and values, the collaboration builds a community development model to strengthen families so that children will be safer in their homes. Parents who could lose their parental rights due to abuse and neglect of their children are encouraged to enter substance abuse treatment in a culturally appropriate and supportive manner. These parents are a priority population for YKHC's substance abuse treatment services. A Community Holistic Development Program conducts presentations on grief processes, youth conferences, healing circles, "Spirit Camps," and other health promotion activities. This program integrates the cultural, traditional, and spiritual values of the people in partnership with other family-based counseling services.

YKHC experiences significant challenges in several areas including: capacity and administrative infrastructure, such as billing, business technology, and data; staff recruitment and retention; enrollment and re-enrollment of children into Medicaid; transportation to and from the villages; and a lack of service capacity. However, a number of strategies have been implemented to address some of these challenges. For example, YKHC finances the education of behavioral health aides as a strategy for recruiting and retaining qualified staff to provide children's behavioral health services. Many training activities are provided, and YKHC pays staff while they are in training.

# Conclusion

## Technical Assistance

The sites reported a number of common technical assistance needs to help them to further develop and improve their financing strategies for their systems of care. The technical assistance deemed necessary for progress includes the following:

- **Medicaid** — Several of the sites indicated that technical assistance related to Medicaid is an increasingly urgent need. Technical assistance is needed to understand the Medicaid program, avoid pitfalls with the program in the current climate, and improve documentation in preparation for federal audits. Concern was raised by several sites about the potential impact of federal audits, as well as administrative rulings requiring unbundling of program costs, on their systems of care and behavioral health services that are funded by Medicaid. For most sites, Medicaid financing is the foundation of their systems. Partnership and technical assistance from the state Medicaid agency was considered essential by a number of the sites.
- **Developing a Comprehensive, Cross-Agency Financing Plan** — Although many of the sites studied have numerous effective financing strategies in place, they identified a need for assistance in developing a comprehensive financing plan that takes an even greater cross-agency view of financing children’s behavioral health services.
- **Pay for Performance Arrangements** — Several sites indicated a need for technical assistance on pay for performance arrangements or performance-based contracting.
- **Determining Costs and Setting Rates**

## Contextual, Environmental, Fiscal or Other Factors that Will Influence Financing Policies and Strategies for Systems of Care

The sites identified a number of factors that are likely to influence financing policies and strategies for their systems of care. These include a host of contextual, environmental, fiscal, and other factors that may impact the sites in the future:

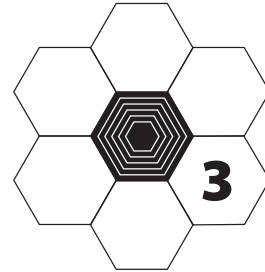
- Leadership changes at the state level and resultant changes in policy that leave system of care reforms vulnerable
- Shifts in Medicaid financing federally
- Increased scrutiny of states’ use of Medicaid
- End of lawsuits and accompanying court monitoring and potential difficulty in maintaining state’s financial and policy investment in the children’s mental health system
- Reductions in federal funding
- Shrinking psychiatric services and qualified providers
- Need to better link health care and behavioral health care
- Emerging new populations (e.g., children and adolescents with co-occurring conditions, such as autism) and burgeoning existing populations (juvenile corrections) that increasingly compete for scarce resources

As a follow-up to this study, each of these sites will be interviewed by telephone to further identify and discuss the impact of contextual, environmental, fiscal, and other factors on their financing policies and strategies for systems of care and what actions or adjustments these sites have implemented in response.



**RTC Study 3:**  
Financing Structures and Strategies  
to Support Effective Systems of Care

**\$15.00**  
**FMHI Pub #235-02**  
184 pages



# Effective Financing Strategies for Systems of Care: **Examples from the Field**

*A Resource Compendium for Developing a Comprehensive Financing Plan*

Beth A. Stroul, M.Ed., Sheila A. Pires, M.P.A., Mary I. Armstrong, Ph.D., Jan McCarthy, M.S.W., Karabelle Pizzigati, Ph.D., & Ginny M. Wood, B.S.

## To Order FMHI Pub #235-02

**Second Technical Assistance Document** assisting child mental health care advocates, stakeholders and policy-makers to identify and implement effective financial strategies and approaches to improved care for children and their families.

To order a printed copy of FMHI Pub #235-02  
mail or fax order form below with payment to:

**FMHI Library/Technical Publications**  
**Louis de la Parte Florida Mental Health Institute**  
**University of South Florida**  
13301 Bruce B. Downs Boulevard  
Tampa, FL 33612-3899

**Phone:** (813) 974-4471    **Fax:** (813) 974-7242  
**SunCom Phone:** 574-7241    **SunCom Fax:** 574-7242

## Produced in Cooperation with:

**Research and Training Center  
for Children's Mental Health**  
Department of Child and Family Studies  
Louis de la Parte Florida Mental Health Institute  
University of South Florida  
Tampa, FL

**National Technical Assistance Center  
for Children's Mental Health**  
Georgetown University Center for Child  
and Human Development  
Washington, DC

**Human Service Collaborative**  
Washington, DC

**Family Support Systems, Inc.**  
Peoria, AZ

**Email:** cone@fmhi.usf.edu



Research and Training Center  
For Children's Mental Health



This publication is also available **FREE** on-line as a downloadable Adobe Acrobat PDF file:

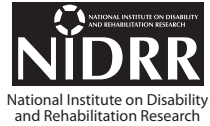
<http://rtckids.fmhi.usf.edu/study03.cfm> or

<http://pubs.fmhi.usf.edu> click **Online Publications** (By Subject)

Please send \_\_\_\_\_ copies of **FMHI Pub #235-02** with payment to the person/organization, and address listed below.  
*Effective Financing Strategies for Systems of Care: Examples from the Field*

Name	Title	Quantity at \$15.00 Each	Total \$ Amount of Order
Organization/Agency			
Street/Shipping Address		Suite	
City		State	Zip
County ( ) ( )		Country	
Area Code	Phone Number	Area Code	Fax Number
E-mail Address		Web Address	
Make Payment to <b>Louis de la Parte FMHI Auxiliary Fund</b>			
Payment by Credit Card Type		<input type="checkbox"/> Payment by PO Number	<input type="checkbox"/> Payment by Check Number
<input type="checkbox"/> Master Card <input type="checkbox"/> Visa		<input type="checkbox"/> Discover Card	<input type="checkbox"/> American Express
Credit Card Number	Expiration Date	Security Code	Your Initials

Mail or Fax this ORDER FORM for #235-02



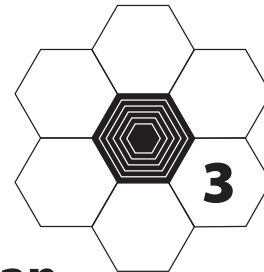
Louis de la Parte  
Florida Mental Health Institute

© 2007, Louis de la Parte  
Florida Mental Health Institute



**RTC Study 3:**  
Financing Structures and Strategies  
to Support Effective Systems of Care

**\$10.00**  
FMHI Pub #235-01  
54 pages



# A Self-Assessment and Planning Guide: Developing a Comprehensive Financing Plan

Mary I. Armstrong, Ph.D., Sheila A. Pires, M.P.A., Beth A. Stroul, M.Ed., Jan McCarthy, M.S.W., Ginny M. Wood, B.S., & Karabelle Pizzigati, Ph.D.

## To Order FMHI Pub #235-01

**First Technical Assistance Document** assisting child mental health care advocates, stakeholders and policy makers to identify and implement effective financial strategies and approaches to improved care for children and their families.

To order a printed copy of FMHI Pub #235-01  
mail or fax order form below with payment to:

**FMHI Library/Technical Publications**  
**Louis de la Parte Florida Mental Health Institute**  
**University of South Florida**

13301 Bruce B. Downs Boulevard  
Tampa, FL 33612-3899

**Phone:** (813) 974-4471

**Fax:** (813) 974-7242

**SunCom Phone:** 574-7241

**SunCom Fax:** 574-7242

## Produced in Cooperation with:

**Research and Training Center  
for Children's Mental Health**  
Department of Child and Family Studies  
Louis de la Parte Florida Mental Health Institute  
University of South Florida  
Tampa, FL

**National Technical Assistance Center  
for Children's Mental Health**  
Georgetown University Center for Child  
and Human Development  
Washington, DC

**Human Service Collaborative**  
Washington, DC

**Family Support Systems, Inc.**  
Peoria, AZ

**Email:** cone@fmhi.usf.edu



Research and Training Center  
For Children's Mental Health



This publication is also available **FREE** on-line as a downloadable Adobe Acrobat PDF file:

<http://rtckids.fmhi.usf.edu/study03.cfm> or

<http://pubs.fmhi.usf.edu> click **Online Publications** (By Subject)

Please send \_\_\_\_\_ copies of **FMHI Pub #235-01** with payment to the person/organization, and address listed below.  
*A Self-Assessment and Planning Guide: Developing a Comprehensive Financing Plan*

Name	Title	Quantity at \$15.00 Each	Total \$ Amount of Order
Organization/Agency			
Street/Shipping Address		Suite	
City		State	Zip
County		Country	
( )	( )		
Area Code	Phone Number	Area Code	Fax Number
E-mail Address		Web Address	
Make Payment to <b>Louis de la Parte FMHI Auxiliary Fund</b>			
Payment by Credit Card Type		<input type="checkbox"/> Payment by PO Number	<input type="checkbox"/> Payment by Check Number
<input type="checkbox"/> Master Card	<input type="checkbox"/> Visa	<input type="checkbox"/> Discover Card	<input type="checkbox"/> American Express
Credit Card Number	Expiration Date	Security Code	Your Initials

Mail or Fax this ORDER FORM for #235-01



National Institute on Disability  
and Rehabilitation Research



UNIVERSITY OF  
SOUTH FLORIDA

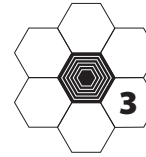
Louis de la Parte  
Florida Mental Health Institute

© 2007, Louis de la Parte  
Florida Mental Health Institute

Order Forms



**RTC Study 3:**  
Financing Structures and Strategies  
to Support Effective Systems of Care



**Issue Brief 1**

**Issue Brief 1: Effective Strategies to Finance a Broad Array of Services and Supports**

Beth A. Stroul, M.Ed.

**Suggested Citation:**

Stroul, B. A., (2007). *Issue brief 1: Effective strategies to finance a broad array of services and supports (RTC study 3: Financing structures and strategies to support effective systems of care, FMHI pub. #235-IB1)*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute (FMHI), Research and Training Center for Children's Mental Health. (FMHI Publication #235-IB1)

**\$6.00**  
FMHI Pub #235-IB1  
12 pages

**Issue Brief 2: Effective Strategies to Finance Family and Youth Partnerships** **Issue Brief 2**

Sheila A. Pires, M.P.A. and Ginny Wood

**Suggested Citation:**

Pires, S.A., & Wood, G. (2007). *Issue brief 2: Effective strategies to finance family and youth partnerships (RTC study 3: Financing structures and strategies to support effective systems of care, FMHI pub. #235-IB2)*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute (FMHI), Research and Training Center for Children's Mental Health. (FMHI Publication #235-IB2)

**\$6.00**  
FMHI Pub #235-IB2  
16 pages

To order a printed copy of FMHI Pub #235-IB1 and/or #235-IB2 mail or fax the order form below with payment to:

**FMHI Library/Technical Publications**  
**Louis de la Parte Florida Mental Health Institute**  
**University of South Florida**  
13301 Bruce B. Downs Boulevard  
Tampa, FL 33612-3899

RTC Study 3 publications are also available **FREE** on-line as downloadable Adobe Acrobat **PDF** files:  
<http://rtckids.fmhi.usf.edu/study03.cfm> or  
<http://pubs.fmhi.usf.edu> click **Online Publications** (By Subject)

**Phone:** (813) 974-4471 **Fax:** (813) 974-7242  
**SunCom Phone:** 574-7241 **SunCom Fax:** 574-7242 **Email:** cone@fmhi.usf.edu

**Mail or Fax this Order Form for #235-IB1 & #235-IB2**

Please send \_\_\_\_\_ copies of **FMHI Pub #235-IB1** with payment to the person/organization, and address listed below.  
*Issue Brief 1: Effective Strategies to Finance a Broad Array of Services and Supports*

Please send \_\_\_\_\_ copies of **FMHI Pub #235-IB2** with payment to the person/organization, and address listed below.  
*Issue Brief 2: Effective Strategies to Finance Family and Youth Partnerships*

Name	Title	Quantity at \$6.00 Each	Total \$ Amount of Order
Organization/Agency			
Street/Shipping Address		Suite	
City		State	Zip
County		Country	
( )	( )		
Area Code	Phone Number	Area Code	Fax Number
E-mail Address		Web Address	
Make Payment to <b>Louis de la Parte FMHI Auxiliary Fund</b>			
Payment by Credit Card Type		<input type="checkbox"/> Payment by PO Number <input type="checkbox"/> Payment by Check Number <input type="checkbox"/> Master Card <input type="checkbox"/> Visa <input type="checkbox"/> Discover Card <input type="checkbox"/> American Express	
Credit Card Number		Expiration Date	Security Code    Your Initials



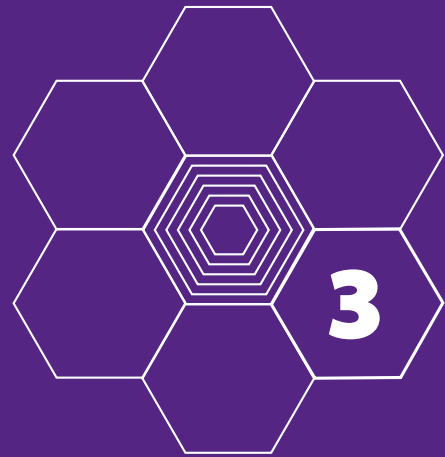
Louis de la Parte  
Florida Mental Health Institute

© 2007, Louis de la Parte  
Florida Mental Health Institute





The Research and  
Training Center for  
Children's Mental Health



**Research and Training Center for Children's Mental Health**

Department of Child and Family Studies

**Louis de la Parte Florida Mental Health Institute**

University of South Florida

Tampa, FL

**Human Service Collaborative**

Washington, DC

**National Technical Assistance Center for Children's Mental Health**

Georgetown University Center for Child and Human Development

Washington, DC

**Family Support Systems, Inc.**

Peoria, AZ