

SECTION 3

Concluding Observations

REMAINING CHALLENGES

Despite the phenomenal progress made by the sites, they continue to face challenges:

Service Capacity and Provider Network—Even with structures in place to coordinate care, to communicate across systems, and to involve families in service planning, several of the sites believe that they do not have sufficient service capacity to meet the needs of children and families in the child welfare system. They continue to seek new providers and to encourage old providers to “retool” the way they do business, but waiting lists for services still exist. It continues to be difficult to find appropriate providers in rural areas and providers who are familiar with the diversity of cultures represented in the child welfare system.

Involvement of Families at the System Level—Respondents from several sites recognized that families are the ones with the expertise to pinpoint needed resources and to make recommendations about policy change, but most had not created a structure or a systematic way to reach out to families from the child welfare system and to request their input.

Role Clarification—Even with strong collaboration during the planning phases, when a care coordinator takes on responsibilities that have traditionally belonged to front-line social workers, the process of “letting go” is difficult for some social workers.

Measuring Change and Outcomes—Several of the sites noted the need for “proof” of their effectiveness and wished that they had additional resources for more comprehensive program and outcome evaluations.

Serving Children Who Are Not Eligible for Medicaid—Because Medicaid is the primary funding source for most of these initiatives, it has been a challenge to develop strategies for serving children who are not eligible for Medicaid.

KEY STRATEGIES

The sites described in this paper have creatively developed unique strategies for making their efforts work in their own states and communities. However, several sites noted similar key strategies.

Collaborative Relationships—All of the sites described long-term collaborative relationships among systems that have sustained their efforts. Trust, respect, persistence, and dedication were words used to describe the relationships among child welfare, mental health, and the Medicaid agency in most of the sites. They expressed a sharing of core beliefs and a willingness to work through problems together. In all of these sites there is top-level commitment from the child welfare, mental health and Medicaid systems to make the initiative work.

Communication Systems—Along with collaborative relationships, strategies to ensure ongoing communication were noted. Some sites specified primary liaisons between systems; and in two sites, care coordinators ensured that families, providers, and systems communicated on a regular basis. Child welfare service plans that addressed safety, permanency and well-being were integrated with health and behavioral health plans through the care coordinators. Clinical review team meetings and interagency administrative staff meetings were common forms of communication.

Funding Strategies—Each of the four sites figured out funding strategies that enabled them to implement the initiative. Medicaid was a major source of funding in each of the sites, but the child welfare agency also contributed funds, space, and staff resources. Foundation funds and tobacco settlement funds also played a part.

In addition to tapping into a variety of funding sources, specific funding strategies were put into place, for example:

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- In one site the child welfare agency and the behavioral health organization realized that they needed to coordinate in setting provider rates so that they would not be competing with each other for providers.
- The Massachusetts Medicaid agency has established a limited no-risk capitated payment arrangement with its contracted managed care organization which is intended to meet the contractor's service costs for each child enrolled in the Pilot program, Special Kids ♥ Special Care.
- When the child welfare agency (DPSS) in Riverside County was able to leverage federal Medicaid funds to pay for the ACT clinicians and to reimburse providers for services, the agency was able to reduce its local expenditures. However, DPSS also agreed to reimburse the Department of Mental Health for all costs for services that were not reimbursed by Medi-Cal, to use DPSS funds to enable ACT clinicians to do some direct clinical work, and to fund services (not reimbursable through Medi-Cal) for family members of children in care.
- To create the Adoption Clinic in California, the child welfare agency contributed start-up costs, and the county managed mental health plan contracted with the Kinship Center for ongoing services. When neither of these agencies could fund needed expansion, the Kinship Center applied for and received funds from the Children and Families Commission.
- Most of these sites indicated that decisions about services were driven by the needs of the child and family, not by which agency was responsible for payment.

Increasing the Clinical Expertise of the Child Welfare Agency—Three of the four sites felt that due to the initiative, the clinical expertise of social workers in the child welfare agency increased significantly. Ongoing consultation with clinicians, advice from care coordinators, and review team meetings were three contributing strategies.

Government Entities and a Non-Profit Serving as MCO/BHOs—In three of the four sites, the county or city operated the managed care organization for behavioral health services. One of the sites described this as the child welfare agency and the BHO “being on the same side”. The non-profit health plan that manages the pilot in Massachusetts has many years experience serving Medicaid consumers and operating a care coordination model. Two of the sites described willingness on the part of the MCO/BHO to access providers outside of the established network when needed for a child and family's individual needs.

Families—While only one of the sites described active involvement of family members in planning and implementing the initiative, they all described the child and family's need for services as the rationale for decisions made. The first priority is to determine what services are needed and which providers to use. Determining payment responsibility follows. This attitude was expressed by child welfare, Medicaid and behavioral health respondents.