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Description of Promising Approaches

Philadelphia, Pennsylvania—Collaborative efforts among three entities - the Philadelphia Department of Human Services (DHS), Behavioral Health System, and Family Court - have led to multiple strategies to assist children and families in the child welfare system to access appropriate behavioral health services. Special units created at DHS and at Family Court work closely with the city-operated managed behavioral health organization (Community Behavioral Health) to integrate behavioral health and child welfare operations and services.

Kinship Center®, Monterey County, California —Kinship Center, a child placement and mental health organization licensed statewide in California, has brought public mental health funding into pre-and post-adoption clinical services. Through the use of Medi-Cal funding, a contract with Orange County Health Care Agency (the county-operated managed mental health plan), and creative funding arrangements, two clinical programs have been established to serve 1) children who are permanently placed with relatives, foster parents, or new adoptive parents, and 2) infants and young children entering the Orange County foster care system.

Special Kids ♥ Special Care, Massachusetts—Special Kids ♥ Special Care is an approach to medical care coordination for children in foster care who have special health care needs being pilot tested by the MA Division of Medical Assistance (DMA) in collaboration with the MA Department of Social Services and Neighborhood Health Plan (NHP), a non-profit managed care organization that contracts with DMA. A community-based nurse practitioner manages each child’s care while serving as the direct care provider of the primary care team. The program incorporates a monthly capitated payment rate for each enrolled child.

Assessment and Consultation Team, Riverside County, California—The Assessment and Consultation Team (ACT) was created through an interagency agreement between two Riverside County departments—Department of Mental Health (the county-operated managed mental health plan) and Department of Public Social Services. ACT places 13 mental health clinicians in DPSS offices throughout the county to ensure access, through the county’s managed care plan, to community-based mental health services for children in the child welfare system.

The four approaches described in this section were identified through the HCRTP and other sources as incorporating features that support effective service delivery within publicly financed managed care for children in the child welfare system who have behavioral health needs, and their families.

These four approaches are not identical, nor are they very similar to one another. It is their differences that enable them, as a group, to offer a comprehensive view of approaches for addressing the needs of children and families in the child welfare system. However, there are important similarities among the sites. All four initiatives resulted from strong interagency collaboration. Three of the four (Philadelphia, Riverside County, and the Kinship Center) utilize

behavioral health carve outs.¹⁴ One (Massachusetts) is part of an integrated physical health/behavioral health design.¹⁵ Three of the initiatives are operated at a county level, one is a statewide pilot. In three of the initiatives, the county serves as the mental health managed care plan (the MCO), and one is managed by a non-profit health care plan. All but one of the sites “blend”, “braid” or use two or more funding sources.

¹⁴ Carve outs are defined by the HCRTP as those managed care plans in which behavioral health services are financed and administered separately from physical health services.

¹⁵ Integrated designs are defined by the HCRTP as those in which the financing and administration of physical and behavioral health services are integrated, even if behavioral health services are subcontracted.

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The sites vary in a number of ways such as the scale of the initiative serving from 70 children in the Massachusetts pilot to 17,000 in Philadelphia. Two initiatives serve both children in their own homes and children in out-of-home placement (Philadelphia and Riverside); two serve children in foster care (Massachusetts and Kinship Center); and one (Kinship Center) focuses on children in adoptive homes and permanent kinship homes. The sites are located on the east and west coasts, in urban, rural and suburban areas.

Each site is engaged in promising approaches for five to eight of the 15 critical components described in Section I. Together the sites represent strategies for implementing all but two of the components. We have not described efforts in relation to information technology and management of data or training and informational materials. While some or all of these four sites are working on these two components, they were not areas identified as promising approaches.

As mentioned in the introduction to this paper, the strategies described in this series of approaches are not intended to be “model approaches” that can be transplanted from one community or state to another. For a variety of reasons, what may work in one place may not work at all in another. However, we hope that readers will be able to see within the descriptions certain parts of the approaches that interest them. We also expect that readers will identify aspects of the approach that would need to change in order for it to work in their own locales.

We believe that consideration of the components described Section I, along with information about specific sites will help states and communities begin to assess and prioritize changes they would like to make in their own systems. For additional information about specific sites, see the contact information that is provided at the end of each site description.

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PHILADELPHIA, PENNSYLVANIA

The Philadelphia Department of Human Services (DHS - Philadelphia's child welfare agency), and Philadelphia's Behavioral Health System¹⁶ are engaged in promising approaches for integrating child welfare and behavioral health services. Described below is background information on managed care in Pennsylvania and in Philadelphia, as well as some of the approaches being used to meet the behavioral health needs of children and families involved with the child welfare system. The approaches described are organized by the following components:

- collaboration
- access
- coordination of care
- clinical criteria
- expanding the service array
- funding.

OVERVIEW OF THE PENNSYLVANIA BEHAVIORAL HEALTH SYSTEM

HealthChoices is Pennsylvania's statewide Medicaid managed care program for adults and children that is being rolled out across the state incrementally. Behavioral health services in Pennsylvania are administered and financed separately from physical health care through a behavioral health carve out in which counties have the right of first opportunity to contract with the state Office of Mental Health and Substance Abuse Services to act as their own managed care entity. Counties also may choose to subcontract MCO functions to commercial or non-profit organizations. State contracts with counties for available Medicaid dollars are risk-based.

In designing the behavioral health carve out in HealthChoices, Pennsylvania intentionally built on its history of using local "systems of care" to serve children with, or at risk for, serious emotional disorders. Requests for Proposals and contracts require incorporation of system of care values, principles and infrastructure. The HealthChoices' performance monitoring system has indicators tied to system of care principles, and the state's Readiness Assessment

Instrument (which gauges the readiness of counties for managed care) incorporate criteria based on system of care principles.¹⁷ These system of care values which call for family involvement, cultural competence, interagency coordination, individualized service planning and the provision of services in normalized (i.e., home and community-based) settings,¹⁸ are evident in Philadelphia's behavioral health system.

OVERVIEW OF THE PHILADELPHIA BEHAVIORAL HEALTH SYSTEM

Philadelphia chose to operate its own behavioral health managed care organization, Community Behavioral Health (CBH), and does **not** subcontract MCO functions to other organizations. In Philadelphia, all Medicaid funded behavioral health services are administered and funded through CBH.

CBH has contracts with almost 300 area treatment providers. CBH "in-plan" services include inpatient hospitalization, partial hospitalization, psychiatric outpatient services, residential treatment for children, Early Periodic Screening, Diagnosis and Treatment (EPSDT) for children, drug and alcohol hospital and non-hospital based rehabilitation programs, methadone treatment, and intensive outpatient

¹⁶ The Behavioral Health System (BHS) in Philadelphia includes the Office of Mental Health (OMH), the Coordinating Office for Drug and Alcohol Abuse Programs (CODAAP), the Office for Mental Retardation Services (OMRS) (including Early Childhood Development Services), and Community Behavioral Health (CBH). CBH is the behavioral health managed care organization in Philadelphia.

¹⁷ Pires, S. A. (2002). *Health Care Reform Tracking Project (HCRTTP): Promising Approaches for Behavioral Health Services to Children and Adolescents and Their Families in Managed Care Systems – 1: Managed care design and financing*. Tampa, FL: Research and Training Center for Children's Mental Health, Department of Child and Family Studies, Division of State and Local Support, Louis de la Parte Florida Mental Health Institute, University of South Florida. (FMHI Publication 211-1)

¹⁸ System of care values and principles are discussed in B. Stroul and R. Friedman. (1986). (Rev. ed.) *A System of Care for Children and Youth with Severe Emotional Disturbances*. Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health, 1986, 17.

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programs. Services directed to the unique needs of children in foster care have been developed by a few of the foster care provider agencies and mental health providers. These services are usually more attentive to issues such as separation, attachment and mental health diagnoses common among children in foster care; however, they are limited in availability.¹⁹

Currently, Philadelphia's BHS provides services to approximately 75,000 adults and children annually. In 2001 almost 20,000 children living in families with low incomes received outpatient mental health care services; 3,000 children were seen in the children's mental health emergency room, 2,500 received treatment in day programs, 2,100 were treated in an inpatient hospital and almost 1,500 received care in residential treatment programs. Many more children received services through their schools.²⁰ A great percentage of the children served by CBH are involved with DHS. In FY 00, CBH served 17,297 children who were identified by DHS. This includes both youth who were dependent and those who were delinquent.

BHS strives to provide child and adolescent mental health and substance abuse services for Medicaid recipients that are superior to what is available to those who are privately insured. As a result, Philadelphia's Behavioral Health System has received national recognition for its vision and commitment to providing mental health services for low-income children and their families.²¹

COLLABORATION

Despite the guidance of strong values and the desire to provide quality behavioral health services described above, community leaders recognized that children and families served by DHS often have difficulty accessing behavioral health services. With support and direction from top-level administrators in the city, e.g., the director of Social Services²², multiple strategies have been undertaken to strengthen collaboration between DHS, CBH and other key organizations to ensure appropriate service provision. This ongoing top level commitment to collaboration and integration, which has become the way of doing business in Philadelphia, guides and provides continuity for the collaborative strategies described below.

Weekly BHS/DHS Integration Meetings

Regular weekly "BHS/DHS Integration Meetings" were instituted in mid-2000. These Friday morning meetings include not only DHS and CBH leaders, but also administrators from the Office of Mental Health, the Office of Mental Retardation Services, the Coordinating Office of Drug and Alcohol Programs, and others. The integration meetings are designed to discuss and resolve cross-system problems. Each meeting addresses issues related to business integration, finances, program development, and providers. Participants in these meetings say that they focus on the families, not on the rules, in order to develop strategies for making services accessible.

Behavioral Health and Wellness Support Center (the Center)

In December 2001, the Philadelphia Department of Human Services (DHS) established a Behavioral Health and Wellness Support Center (the Center) to more effectively meet the mental health needs of children and families involved with DHS; to improve access to behavioral health services for these children and families; and to the extent possible, to integrate behavioral health and DHS operations and services. The Center is a result of collaboration between DHS and BHS. Primary tasks of the Center include:

- managing a help desk to assist DHS and DHS provider agencies in accessing behavioral health services and resolving cross-system problems;
- assisting children and families in navigating the managed care system;
- advocating with the behavioral health system for families involved with DHS and for DHS staff;

¹⁹ Forkey, H. C. (July 2002). Mental Health Services for Children in Substitute Care in Philadelphia (DRAFT), 14.

²⁰ Forkey, Mental Health Services, 13.

²¹ Forkey, Mental Health Services, 12.

²² The Director of Social Services administers both DHS and BHS in Philadelphia. When the Director of Social Services, Estelle Richman, later became Philadelphia's Managing Director, she continued to promote the integration of the behavioral health and child welfare systems.

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- ensuring coordinated discharge planning and rapid discharges from psychiatric hospitals for children involved with DHS;
- assisting in transitioning children from out-of-state residential treatment facilities (RTFs) and stabilizing their placements in the Philadelphia area;
- promoting timely and comprehensive discharge planning for children who are aging out of the DHS system and into the adult behavioral health system;
- receiving and resolving complaints about BHS services and cross-system problems;
- providing clinical consultation and training on mental health issues for DHS staff;
- attending family service planning meetings and discharge planning meetings with case managers, as needed
- securing behavioral health assessments and interpreting them for DHS staff and for DHS provider agency staff;
- providing clinical direction to DHS staff in sexual abuse and sexual health issues;
- securing permanency evaluations for children in very complex situations.

The Behavioral Health and Wellness Support Center provides a “**one-stop**” location for DHS case managers, provider agency staff, and CBH to begin problem solving around behavioral health services for children and families. A number of special service units that previously existed in DHS have been brought together, and they now form the Center. This includes service units that address:

- referral for placements (central referral),
- complex behavioral health case management,
- sexual abuse services,
- residential treatment facilities,
- early childhood, and
- the psychologists unit.

The clinical psychologists unit provides behavioral health expertise through in-person consultations, by phone and by e-mail to assist DHS social workers and

provider agency social workers. As needed, the psychologists contact CBH about specific children and families rather than having 700 different social workers calling CBH. The psychologists also help workers determine whether court-ordered evaluations should be arranged by CBH or by the DHS psychology unit. They also arrange appropriate sexual abuse and sexual behavior evaluations, whether or not they have been court ordered, in order to assess the child’s treatment needs and to help DHS and Family Court make decisions about children’s safety.

The Center serves as a liaison between DHS and CBH. The Center’s involvement in behavioral health assessments and in discharge planning from inpatient psychiatric units provides examples of this role. When a **behavioral health assessment** is provided through CBH, the assessment is sent back to the DHS worker through the Center. A psychologist reviews each assessment before forwarding it on to the DHS worker and consults with the worker on needed follow-up. The DHS worker then includes this information in the family service planning process. If needed, the psychologists can appear in court to address behavioral health issues.

In 2001, DHS and CBH agreed to a **joint protocol on procedures for discharge planning** for children who are admitted to inpatient psychiatric units. The intent of these procedures is to clarify roles (CBH, DHS, inpatient facility), to begin early care coordination for children who are admitted, and to holistically support children and their families, as children transition from one level of care to another. According to these procedures, the Behavioral Health and Wellness Support Center notifies DHS workers by e-mail immediately after a child in their caseload is admitted to an inpatient facility. DHS workers are then expected to notify parents, guardians, and other involved persons of the child’s hospitalization and to communicate with the child’s CBH care manager about discharge planning. The Center contacts DHS supervisors to ensure that this coordinated planning between the CBH care manager and the DHS social worker takes place. The Center trained all supervisors on these new procedures.

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The Central Referral Unit supervisors from the Behavioral Health and Wellness Center meet several times a day with care managers from CBH to solve any problems regarding an individual child situation. They discuss what a child needs, **not** who is responsible for payment. Once needs and services are determined, if there is a question about payment responsibility, higher level administrators make this determination.

The Center also addresses joint program and resource development activities, such as the current effort to develop more extensive treatment foster care services and to expand sexual abuse treatment services in Philadelphia. Communication between the Center and CBH, is continuous. The director of the Center participates in the weekly BHS/DHS Integration meetings mentioned above.

Collaboration with Family Court

For the past six years, the Philadelphia Family Court has conducted an on-going re-examination of the court's handling of child abuse, neglect and dependency cases; assembled knowledge concerning best practices; and tested possible innovations as part of its involvement in the ongoing national Court Improvement Project (CIP). DHS and BHS (including CBH), along with a number of other health, legal and advocacy organizations, typically are represented in the Family Court Improvement Program Committee that meets monthly. A workgroup of this Committee, the Behavioral Health Service Workgroup, also meets monthly.²³ Philadelphia is engaged in two court initiatives that address behavioral health services and involve both DHS and CBH:

- Pre-Hearing Conferences
- BHS Family Court Unit.

Pre-Hearing Conferences

All new adjudicatory hearings, an average of eight per day (2,200 families/year), now include a pre-hearing conference. The pre-hearing conference invites all parties to participate—parents/guardians, their attorneys, and other interested persons such as family members or close friends, the DHS social worker, private provider social workers, DHS attorneys, child advocates, BHS family court clinician and liaison,

CASAs, and others who the parties believe to be appropriate. An outside facilitator convenes the pre-hearings.

The purpose of the pre-hearing conference is to determine what, if any, services are needed for a family to resolve the given situation and to help parents maintain a safe, nurturing, and permanent environment for their children. These pre-hearings also provide the opportunity for immediate referrals for quality behavioral health assessments and services for families in Dependency Court. Issues of dependency, placement, visitation, and services are discussed, as appropriate. Possible solutions and plans of action are discussed, and recommendations about final actions are developed.

The hearings last for 30 minutes and occur just before the adjudicatory hearing. Parents are asked to consent to release information about their family's mental health and drug and alcohol history. Later at the adjudicatory hearing, the judge decides any outstanding issues not agreed upon at the Pre-Hearing Conference (PHC), and determines, based on recommendations from the pre-hearing conference, whether behavioral health assessments are needed for the child or other family members. One goal of the PHC is to "frontload" the court process by identifying issues where agreement exists and services can be initiated.²⁴

The BHS representatives in the pre-hearing conferences address behavioral health issues, authorize and schedule appointments for drug and alcohol assessments and mental health evaluations, usually within a few weeks of the hearing. The clinician has access to the CBH database and with parental permission, can determine if the child has received behavioral health services, and whether an evaluation has been done recently. The involvement of CBH

²³ Hurst, H., Halemba, G., Zawacki, S., and Gunn, R. (2002). *Pennsylvania Court Improvement Project - Assessment of 2001 Initiatives in the Philadelphia Dependency Court*. Pittsburgh: National Center for Juvenile Justice, 1.

²⁴ Information from a brochure for families, "A Guide for Parents and Children - Family Court". Written in English and Spanish.

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clinicians in the pre-hearing helps attorneys and others to make appropriate behavioral health recommendations in court.

The BHS clinician and liaison positions are funded by CBH. The outside facilitator position is funded through the Court Improvement Program.

BHS Family Court Unit

The BHS Family Court Unit, a comprehensive team of BHS professional staff who work on-site at the court, is located right beside the pre-hearing conference room. This team staffs the pre-hearing conferences described above and assists DHS in providing immediate access to psychological evaluations through “on-the-spot” referrals to a preferred provider list of specialists that CBH is developing for DHS and the court. Funding for this unit comes from CBH.

Drug and alcohol assessors are also located in dependency court. These four assessors use tools approved by the Pennsylvania Department of Health, Office of Drug Abuse and Prevention, to assess the need for services. They also make referrals for services through the managed care behavioral health networks available in Philadelphia. They follow-up on completion of services and provide written progress reports to the parties and to the court. When requested, they may appear in court. The Court Improvement Program Committee negotiated the necessary expansion of resources for this team of assessors through the City’s Department of Public Health’s Coordinating Office of Drug and Alcohol Abuse Programs (CODAAP).

The procedures for the activities described above and for relationships between the various provider agencies and professional staff are found in the court’s *Behavioral Health Services Program Protocol for New Dependency Cases*. This Protocol describes specific procedures for staffing the pre-hearing conferences, obtaining the appropriate releases of information at (or prior to) the pre-hearing, conducting assessments, making referrals for assessments, making referrals for treatment, tracking client progress and providing progress reports to the parties and the court.²⁵ This

Protocol was written by representatives of multiple disciplines during Court Improvement Project subcommittee meetings.

ACCESS

Philadelphia has undertaken a number of approaches to improve access to services for children and families served by DHS.

Automatic Enrollment

Children who enter the custody of DHS are presumed eligible for Medicaid and automatically enrolled with CBH. DHS calls an established 1-888 number to enroll each child.

Help Desk

The help desk (described above) located at the Behavioral Health and Wellness Center assists DHS and provider agency workers in accessing appropriate services for children and families.

Authorization

No prior authorization is required for outpatient services.

Written Guides

Two laminated guides—a Wallet Card Guide and a Behavioral Health Referral and Information Expanded Guide—represent the new collaborative work between DHS and the Behavioral Health System. The guides are for child welfare professionals at DHS and in provider agencies to help them access behavioral health and child development services for children and families. The Wallet Card contains the contact numbers needed to access mental health and substance abuse services for HealthChoices members; for ChildLink to help workers obtain developmental screenings for young children, free of charge, regardless of their health care plans; and at CBH for families who have no health insurance. CBH helps find resources for these families.

The Expanded Guide (a small 4-sided document) provides very clear, concise information about how to

²⁵ Hurst, H., et. al. *Pennsylvania Court Improvement Project*, 20-22.

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access early intervention services (birth to age five), court ordered evaluations, sex abuse evaluations, emergency and non-emergency mental health and substance abuse evaluations and services. The guide clearly explains when child welfare workers should call the internal DHS Psychology Unit and when they should call CBH. The Guide includes a Behavioral Health and Developmental Referral Flow Chart.

Out-of-Network Providers

CBH is inclined to use “in network” providers, but through collaboration with the Behavioral Health and Wellness Center around the needs of individual children, out-of-network providers can be used and paid for by CBH.

COORDINATION OF CARE

Care Management Responsibility

Prior to CBH, social workers at DHS and at provider agencies were responsible for coordinating all aspects of a child’s care, including behavioral health services. Now the CBH care manager, not the DHS worker or the provider agency worker, makes all referrals to providers for behavioral health services for children served by DHS. This major shift in philosophy and practice is one result of the integration of DHS and BHS systems.

Integrating Behavioral Services and the Family Service Plan

A greater number of Family Service Plans (FSP) now reflect behavioral health issues of children and parents. Highlighting behavioral health needs and issues in the FSP has been a cultural shift for DHS. CBH and DHS both work to ensure that the goals of DHS intervention with the family and children, as well as the behavioral health recommendations, are integrated into one service plan. An example of this can be found in procedures described in the December 2001 Protocol on Discharge Planning for DHS Children in Inpatient Psychiatric Care. When a child in DHS custody is admitted for inpatient psychiatric care, the CBH care manager participates in an interagency meeting within three days of admission and to coordinate with the DHS social worker the development of the behavioral health components identified on the Family Service Plan.

CLINICAL CRITERIA

Increased Clinical Expertise

Before the integration of DHS and BHS services, DHS social workers had little access to clinical expertise to assist them in serving families and children. For example, DHS social workers often made decisions about moving children from one residential treatment facility to another, without the benefit of clinical expertise. Now with the creation of the Behavioral Health and Wellness Center, ongoing consultation with the Psychologists Unit, access to care managers from CBH, a psychiatrist on site at DHS, and mechanisms for inter-system problem solving, DHS social workers have strong clinical back-up.

EXPANDING THE SERVICE ARRAY

Confronting the Challenges

Having an adequate service array available for children served by DHS continues to be a challenge in Philadelphia. Even when a comprehensive and timely assessment is completed, children may wait for services. Together CBH and DHS have worked to identify service gaps and expand resources. They are currently focusing on therapeutic foster care and sexual abuse treatment services. CBH is also identifying preferred providers who will accept children from DHS for services within five days of referral.

An example of how the systems have worked together to address the need for more services occurred in June 2002. As part of the City’s Children’s Investment Strategy, DHS and BHS committed resources to expand sexual abuse treatment services. To jump start this effort, in June 2002 providers who have experience and expertise in providing sexual abuse treatment services for both perpetrators and victims were invited by BHS and DHS to a meeting to assess the system needs for sexual abuse treatment, discuss the opportunities for collaboration and expansion, to identify next steps, and create a multi-system workgroup to keep these efforts moving forward. The workgroup is developing strategies to train more clinicians about the provision of sexual abuse treatment services.

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FUNDING STRATEGIES

Determining Payment Responsibility

Approximately 90% of behavioral health services used by children in DHS custody are paid by CBH, but services that do not meet medical necessity criteria are paid for by DHS, e.g., court ordered psychological evaluations related to bonding, reunification, and other permanency decisions. DHS psychologists in the Behavioral Health and Wellness Center distinguish between CBH-funded and DHS-funded services. The protocol that governs inpatient discharge planning specifies that funding is determined based upon “eligibility status and/or medical necessity criteria and supports needed to ensure implementation of the care plan”. Specific funding requests are submitted to the respective parties within BHS and DHS for review and processing.

DHS and CBH have found that they need to consult with each other when they make fiscal decisions. For example, the two systems were paying providers different rates for the same services and had to adjust their rate schedules. Fiscal and program staff from both systems participate in the weekly BHS/DHS Interagency Meeting.

Funding the Behavioral Health and Wellness Center

The BHWC is funded solely by DHS. Prior to the creation of BHWC, many of its staff worked in units spread throughout the agency. Creating the BHWC consolidated many of these units (for example, the central referral unit, the residential treatment facility unit, the psychologists unit) into one Center. During the past few years DHS has expanded its staff agency-wide by about 300 positions. A few of these new positions have been dedicated to the BHWC.

KEY COLLABORATIVE STRATEGIES

As previously mentioned, ongoing collaboration has become the way that DHS and CBH do business. Before the two systems began working on integrating services, parallel behavioral health systems existed within each system. DHS found itself arguing with the Office of Mental Health and CBH to get services. **Top-level commitment** to a collaborative

attitude and regular intersystem meetings at all levels has changed this dynamic. The model for collaboration in Philadelphia comes from the top. Front line staff know that top-level management in different systems will meet to resolve problems that arise. They put problems on the table and work together to resolve them. They expect staff at other levels to adopt this same approach to collaboration and have instituted a number of communication tools to promote this approach - brochures, newsletters, marketing efforts, and training. Subcommittees of staff from various levels often do the work to create the system changes that have been agreed upon by administrators.

Philadelphia attributes its success in collaboration to a number of things:

- top level commitment
- ongoing meetings and communication
- CBH is a city agency, not a commercial for-profit MCO, thus CBH and DHS believe that they are both “on the same side”
- they avoid being sidetracked by rules that do not make sense; instead, they come together around what is important - the children and families
- problem-solving around individual child and family situations often leads to creating system-wide policy
- persistent, long-term work together (have been working at this collaboration for 10 years)
- learning from mistakes.

One example of learning from mistakes relates to on-call responsibility for behavioral health services. In responding to a weekend call for emergency treatment services for a child, CBH needed to reach the child’s family, but could not find them. CBH did not know that DHS had an on-call system set up for just such emergencies. The search reached the top-level administrator in CBH who contacted the DHS administrator and learned that the problem could have been solved much sooner. This precipitated developing written policies about on-call responsibilities that are shared across systems.

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REMAINING CHALLENGES

In spite of extraordinary progress in collaboration, DHS and CBH describe many challenges that remain:

- building the infrastructure and developing the broad array of services needed for children and families involved with the child welfare system takes time and resources. Sometimes even when the systems work collaboratively to provide a special service, the service is not available.
- front-line staff and providers who have not yet adopted collaborative attitudes
- budget cuts
- ongoing work with the school district
- including families and consumers in decisions about policy change
- resources, manpower, and technical support
- trust among systems (still difficult, but grows with ongoing collaboration)
- coordination of physical health and behavioral health care.

A 2002 report on Mental Health Services for Children in Substitute Care in Philadelphia notes DHS and CBH efforts to streamline care for children in inpatient and residential treatment settings through the development of the Behavioral Health and Wellness Center. However, the report also cites ongoing challenges to care coordination and states that while those children with the most complex needs are receiving specialized attention, children who receive outpatient services are not receiving as much attention.²⁶

ADVICE

Participants in the Philadelphia site visit offered the following advice based on their own experiences to other states and communities working on integrating their child welfare and behavioral health managed care systems:

- Create an interagency team that meets regularly to keep things moving and to make decisions.

- Systems need to talk **with** each other, not **to** each other.
- Top level commitment is essential and has been a key to Philadelphia's progress. Agency heads, the administrative judge in family court, and the city's managing director are among those who committed to integration of services.
- Individual leadership is important. For example, to get the court improvement projects moving, the judge committed to success, called other agency heads, told them what she needed, and believed that it could be done.
- Be flexible, you learn as you grow and have to be willing to change if something is not going well. Be prepared to amend decisions as needed based on feedback and outcomes of the decisions.
- The MCO must believe in breaking down barriers to services. Respondents saw CBH as a "MCO in reverse". Instead of creating barriers, it is trying to break down barriers. Respondents stated that the character of CBH is out of character with many MCOs.
- Reinvest profits into services for children and their families.

The DHS Commissioner described five ways for communities to determine whether integration of the child welfare and behavioral health systems is occurring:

- *the culture and the philosophy of the organization*—both systems will feel jointly responsible for child and family well-being
- *policy*—policy will reflect the new culture and philosophy
- *programs and resources*—the infrastructure for program and resource development will be in place and needed services will be available to children and families
- *financing*—funding streams will be integrated as much as structures allow—both systems will be willing to blend funds as much as possible to create needed services

²⁶ Forkey, Mental Health Services, 5.

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- *front line providers*—integration will occur throughout the system, including at the front line service level.

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KINSHIP CENTER[®], MONTEREY COUNTY, CALIFORNIA

Kinship Center, a child placement and mental health organization licensed statewide in California, is reportedly the first agency specializing in adoption services in California to successfully bring mental health funding into pre- and post-adoption clinical services. The collaboration that has occurred among Orange County Social Services Agency (SSA), Orange County Health Care Agency - Children and Youth Services (HCA), Orange County Children and Families Commission, and Kinship Center demonstrates how public and private agencies can work together within the framework of managed care to develop, fund, and provide needed mental health and developmental services for children and families involved with the child welfare system. Described below are:

- a brief description of Kinship Center
- background information on managed care in California
- two mental health and developmental service initiatives—the Adoption Clinic and the Seedling Project (Seedlings), both funded by EPSDT, that have involved Kinship Center in managed care in Orange County, CA.

The information about the two initiatives is organized by the following components:

- collaboration
- funding strategies
- access
- developing service array
- provider network
- family participation
- monitoring and evaluation
- early childhood Issues

KINSHIP CENTER

Kinship Center offers an integrated array of programs to support families including: adoption and foster care; developmental and mental health services; parent and professional education, and special

services such as an adoptive family wraparound pilot program and kinship care services. Kinship Center is licensed to operate statewide. Currently they have six offices around the state, with headquarters in Monterey, CA (Monterey County). Kinship Center was awarded an Excellence in Adoption Award in the category of Support to Adoptive Families by the U.S. Department of Health and Human Services in 2002 in recognition of the work of these two interconnected clinics—The Adoption Clinic and Seedlings Project.

In early 2000, as a result of the joint efforts of the Social Service Agency, Health Care Agency, Orange County Children and Families Commission, and Kinship Center, the **Adoption Clinic** was launched in Orange County. This is California's first outpatient mental health clinic dedicated to children in foster care who are permanently placed with relatives, foster parents, or new adoptive parents. In 2001, the **Seedling Project** was created to ensure that infants and young children in the foster care system have early comprehensive screening, developmental and mental health assessments, and appropriate mental health intervention when required. The Seedling Project also offers highly specialized training and individual coaching for parents and caregivers. Both of these projects have received some grant funds, but they are sustained through Medi-Cal's Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT). To operate these two programs, Kinship Center had to obtain certification as a Medi-Cal provider by the Behavioral Health Services of the Orange County Health Care Agency in the county's managed mental health plan.

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OVERVIEW OF PUBLICLY FUNDED MENTAL HEALTH MANAGED CARE IN ORANGE COUNTY, CALIFORNIA

California has implemented its Medi-Cal²⁷ managed care initiatives primarily on the county level. Counties serve as the local mental health plan manager (MHP) and are responsible for authorizing and paying for all publicly funded mental health services. The California Department of Mental Health played a key role in assigning counties such responsibility.²⁸ In Orange County, where the clinics of Kinship Center are located, the Orange County Health Care Agency (HCA) serves as the MHP and administers the county mental health program. HCA is the formal access point for mental health treatment in the county.

COLLABORATION

Orange County has operated a system of care to meet the mental health needs of children and families for approximately ten years. Child-serving agencies across systems have weathered budget crises together and have used such crises as an opportunity for collaboration. They are experienced at working together.

The Adoption Clinic - How It Evolved

Kinship Center learned from both families and staff that post adoption services were sorely needed in Orange County. In a 1999 survey of adoptive families conducted by Kinship Center and SSA, parents asked for adoption-knowledgeable therapists, education and support groups, educational advocacy and tutoring, and respite services.

A committed administrator from Orange County SSA (who had been an adoption line worker) knew the service gaps and the need for mental health services for adopted children and their families. The director of Kinship Center talked with the SSA administrator and suggested a dialogue between county mental health (HCA) and social services (SSA). HCA already had other local clinics focusing efforts on services for children in foster care. This dialogue took them further and focused on the need for mental health services for children who were moving, or had already moved, into

permanent placements. There was agreement among all on the need for services, but implementation required intensive planning and collaboration. The public agencies' willingness to assist each other with start-up costs and program design was critical to the creation of the Adoption Clinic.²⁹ The Clinic, originally intended to serve 65 children per week, now serves approximately 125 children and their families each week.

The Seedling Project - How It Evolved

The Seedling Project of Kinship Center was created in 2001 in response to a lack of consistent adequate care and follow-up for young children in foster care. The county recognized that infants and toddlers in foster care are at higher risk and require special attention because they have higher rates of abuse, remain in family foster care longer, have lower reunification rates, and experience more failed placements than do older children.³⁰ Initially, SSA was the primary partner for support around the concept of Seedlings. Children in the custody of Orange County were the target population. When the decision was made to expanding Seedlings' existing services to include EPSDT, the partnership grew to include HCA and a more formalized development of the infant/toddler mental health component was created.

While the Seedling Project was initially funded entirely by a grant from the Children and Families Commission (created from tobacco settlement funds), it is now partially funded by the Commission and is sustained through EPSDT and as a developmental program under the Medicaid Rehabilitation Option. The Project serves 90 children and their caregivers each month with services provided in both English and Spanish.

²⁷ Medi-Cal is California's term for Medicaid.

²⁸ *Managed care tracking system: State profiles on public sector managed behavioral health care and other reforms.* (1998). Washington, DC: Substance Abuse and Mental Health Services Administration, 63.

²⁹ Biddle, Carol and Silverstein, Deborah. *Developing Post Adoption Service Models and Sustainable Funding.* *Bridges*. Washington, DC: Administrators of the Interstate Compact on Adoption and Medical Assistance.

³⁰ Horowitz, S. M., Simms, M. D., and Farrington, R. (1994). Impact of Developmental Problems on Young Children's Exits From Foster Care. *Developmental and Behavioral Pediatrics* 15, 105-110.

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FUNDING STRATEGIES

Funding strategies for both the Clinic and the Seedling Project have required collaborative efforts to braid together multiple funding sources. To fund the **Adoption Clinic**, some limited start-up funding was provided by SSA to get the program organized, lease space, and hire key management staff, and Kinship Center was approved as a Medi-Cal provider in the county mental health provider network. However, Kinship Center is not paid through a case rate, nor on a fee-for-service basis. Instead, Kinship Center and HCA negotiated a contract based on an annual budget for the Adoption Clinic. HCA pays one twelfth of the full budget each month. Kinship Center is expected to provide a specific number of billable hours per staff position and reports these billable hours to HCA each month. The county then recoups its costs through EPSDT by charging Medi-Cal for those units of service. Reimbursement to the county from Medi-Cal is slow. The Kinship Center is not large enough, nor does it have a major endowment that would allow it to wait for reimbursement. It cannot handle an irregular flow of income. Through the contract arrangement, the county assumes the risk, and thus far, Kinship Center has been an excellent performer.

The initial plan was for the Clinic to serve 65 children and their families per week, but the demand for services was much greater. The county was not able to fund an expansion, so the director of the Kinship Center sought and received additional funds from Children and Families Commission (mentioned above). Commission funding, used to meet the state/local match to Medicaid, has leveraged the expansion of the Adoption Clinic from serving 65 to 125 children per month. That leveraged strategy was successful, the grant from the Commission has been retired, and the clinic has established fiscal sustainability.

The **Seedling Project** was started with funds from the Children and Families Commission and is sustained with EPSDT funds. Funding from the Commission is used as the state/local match to the federal Medicaid reimbursement. The Children and Families Commission has twice provided leveraged funding for the Seedling project. When it expires, it is expected that Seedlings will have achieved fiscal sustainability through EPSDT.

In order to use Medi-Cal as a funding source for the Seedling Project, children who are served must have DSM IV³¹ diagnoses. *The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC 0-3)* is the more appropriate tool for young children and has been widely accepted since the early 1990's. While some states have a federal Medicaid waiver to use diagnoses from DC 0-3, California does not. In order to properly report services and bill Medi-Cal, Kinship Center must first utilize the classification system within the DC 0-3 and then cross over to the DSM IV. Although comprehensive, the DSM-IV diagnoses are often less inclusive of the many specific symptoms that children within this young population exhibit. As a result of this challenge, mental health professionals nationally have trained Kinship Center staff in understanding how to translate diagnoses for young children into DSM IV language and thus meet the federal Medicaid requirements.

ACCESS

Families can self-refer to the **Adoption Clinic** or be referred by a child serving system. A mailing was sent to all families who receive an adoption subsidy to announce the opening of the Adoption Clinic. The Clinic immediately received 40 calls from families. The Clinic is advertised on Kinship Center's website, through the schools, through private placement agencies and other kinship programs. Primary referral sources are SSA (40%+), response to flyer (15%), private agency (10%+), self-referrals (8%), and other (20%+). The "ticket for services" is a full-scope Medi-Cal card for the child being referred.

SSA is the primary referral source for the **Seedling Project**, referring children under age six who enter foster care. Families can also self refer to Seedlings. The Adoption Clinic and Seedlings refer to each other as appropriate, enabling a child and family to come through either door.

³¹ American Psychiatric Association. (1994). (4th ed.). *Diagnostic and Statistical Manual of Mental Disorders*. Washington: American Psychiatric Association.

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Both clinic programs can provide services for sixty days before authorization is required. During this 60 day assessment period the Clinic determines if the child/family meets medical necessity criteria. The County spot checks once a month by examining charts, and Medi-Cal does an annual review to determine if medical necessity criteria are being met.

DEVELOPING THE SERVICE ARRAY

PSDT allows for service flexibility, so the Adoption Clinic can provide a wide array of services in a variety of locations. The combined Clinics provide individualized services and family based interventions. Staffing includes therapists, case managers, treatment behavioral specialists, and child assessment specialists, and a parent education specialist who is an RN. Contract specialists include a pediatrician, a child psychiatrist, and an occupational therapist who provides assessments and therapy related to sensory motor integration. The Clinic can offer treatment for birth parents as a support service for the child. Pre-placement and post-placement services are offered, including services before and after legalization of the adoption.

Child mental health outpatient services offered by the Clinic for children from birth to 21 include:

- individual, family and group therapy (in the clinic and in-home, available in English/Spanish)
- treatment within a school setting
- psychological testing (when needed)
- psychiatric consultation
- therapeutic behavioral specialists (who work in home with children and parents)
- occupational therapy—sensory motor integration
- collateral and extended kinship family (sometimes renewing relationships with birth families after children have been adopted)
- bilingual services.

Developmental services provided through the Seedling Project include:

- in-home developmental screening (English and Spanish)

- interdisciplinary assessments
- psychological testing (English and Spanish)
- occupational therapy focusing on sensory integration
- child and family-specific support
- parent support sessions, coaching (one on one) and assistance with IEPs.
- advocacy within service systems
- bilingual services
- therapy at the Adoption Clinic

PROVIDER NETWORK ISSUES

To develop these programs the Kinship Center had to be approved by county mental health as a Medi-Cal provider. While the process of becoming a Medi-Cal provider was not too rigorous, the Kinship Center receives a great deal of consultation and support from HCA on Medi-Cal issues, as well as oversight regarding the quality assurance issues. The Center feels that it may be a “high maintenance” provider because it takes time for them to understand the billing procedures. “Adoption” was a new concept to Medi-Cal and did not fit easily into the standard procedures. For example, Medi-Cal requires birth dates and social security numbers. Children who have been adopted may have had more than one social security number, under different names. The county lost a modest amount of funds during the Clinic’s first year when they were unable to resubmit a bill with a new social security number. The Center recognizes that the county has “taken a chance” on using them as a provider and believes that it is working well.

FAMILY PARTICIPATION

Kinship Center actively involves families in choosing and creating the intervention for their own children. The Center involves birth parents as much as possible, even when the child is to be adopted. They encourage birth families to support the treatment process, even after finalization and attempt to create a safe, neutral environment for birth parents. Thirty-five percent (35%) of the children who receive mental health and developmental services from Kinship Center are with relative caregivers, mostly grandparents. Program development at Kinship Center

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is informed by families. Many staff members are also adoptive parents.

CULTURAL COMPETENCE

Kinship Center serves children and families from many cultures. Multilingual services are a critical component of its programs. More than 40% of the children and families in the Adoption Clinic and in the Seedling Project are Hispanic. Staff at Kinship Center speak multiple languages, and other bilingual interpreters are brought in as needed.

MONITORING AND EVALUATION

Outcome measurements have been designed with the help of The Berger Institute at Claremont McKenna University in California, headed by Dr. Diane Halpern, who is also President of the American Psychological Association. The first research and outcomes of the clinics will begin to be published in 2003. In addition, the Institute has tested the Kinship Center Attachment Instrument, the first to measure attachment in children who have been adopted. This instrument will be published and available for use by others in 2003. The contract with county mental health, which must be renewed each year, includes performance measures related to the units of service, and number of children/families served, plus a written record review by the county. The Center has a data base with information such as demographics, amount of treatment provided, and scores on assessment instruments such as the CAFAS and the CBCL³².

The Adoption Clinic has substantiated that many children who are adopted from the county foster care system exhibit a variety of diagnosable mental health disorders that result from abuse, neglect, prenatal substance abuse, loss of primary relationships, and multiple placements in foster care. Clinic staff see that their therapeutic interventions help stabilize families in crisis; increase self-regulatory behaviors of children; improve children's adjustment and function in school; and help heal trauma resulting from prior neglect, abandonment, and abuse. The majority of children are treated without medication.³³

Kinship Center believes that ultimately it saves the child welfare system money, lowers the replacement rate for children in care, and reduces adoption disruptions; but it does not yet have the data to prove this.

EARLY CHILDHOOD ISSUES

Kinship Center recognizes the special needs of young children and through the Seedling Project ensures that infants and young children from the foster care system, as well as their parents or caregivers, have access to early comprehensive screening, developmental and mental health assessments, and appropriate mental health intervention. Parents also can receive skilled training and individual coaching. All of this is provided under rehab option services in MediCal.

The Kinship Center recognized that children in foster care enter early intervention and receive IDEA Part C services at a much greater rate than the general population of children. Most of the children seen at Seedlings are screened because of suspected delays, which then entitle them to receive access to Part C services. Caregivers often seek support from Seedlings with very little knowledge about IDEA. Through the screening process and advocacy training they are offered, caregivers work with the Seedlings team to complete all of the necessary testing and documentation required to ensure their child's eligibility for IDEA supports prior to school entry.

KEY FEATURES

- Trust and respect among SSA, HCA, and Kinship Center. The agencies share core beliefs and have had positive relationships for some time.
- Willingness of SSA and HCA to share start-up costs and help with program design
- Understanding of and strong commitment to the need for services for children who are adopted and their families

³² CAFAS = Child and Adolescent Functional Assessment Scale; CBCL = Child Behavior Check List

³³ Biddle and Silverstein, *Developing Post Adoption Service Models*, 3.

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- Program development guided by what families say they need
- Exploration of different funding strategies, rather than giving up when challenges arise
- Willingness to treat Kinship Center a little differently than larger, long-established provider agencies, e.g., offering ongoing support regarding billing procedures, an annual contract arrangement rather than fee-for-service billing, etc.
- Leveraging other funds (in addition to Medi-Cal)—“the gift that keeps on giving”
- Kinship Center meets the performance expectations in its contract.

REMAINING CHALLENGES

Despite the wonderful progress made in the past few years, Kinship Center described several challenges that remain:

- Conquering the waiting list for Adoption Clinic services (about 30 children on the list, a 2 month wait)
- Overcoming geographic barriers. In California, the county that initially takes custody of a child is responsible for payment for services. When a child in foster care moves to another county, the mental health plan from the original county is responsible for finding and funding needed mental health services in the host county. California has a statewide Memorandum of Understanding that addresses this issue. However, because the Adoption Clinic is funded under a contract with Orange County, its services are not available to children placed from other counties. As yet, there is no mechanism for the originating county to pay for the services offered by the Adoption Clinic in Orange County.
- Serving children who are not eligible for Medi-Cal. The Adoption Clinic is funded primarily by Medi-Cal. This works for most adoptive families because most children who need the services of the Clinic have adoption subsidies and are therefore eligible for Medi-Cal. But there continue to be children in adoptive families who need services but who are not eligible for Medi-Cal.

- Additional funding for more comprehensive program and outcome evaluation
- Speech and language evaluation and treatment services have been identified as additional needed components to clinic services.
- Educational tutoring services are a desired addition to clinic services, as most of the school age children are struggling with disruption in school placements, delayed learning, and are accessible for such services while attending the clinic for individual and family appointments. Finding funds to offer tutoring and educational services for each child (not covered by Medi-Cal) is a challenge. These services, when achieved, will not be Medi-Cal funded, thus other funding sources will have to be identified.
- Mastering the Medi-Cal billing system, making the state codes work for the variety of services offered. Although Kinship Center receives a lot of support from HCA in this effort, it is a constant work in progress

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Special Kids ♥ Special Care

A Medical Pilot Program for Children in Foster Care Commonwealth of Massachusetts

INTRODUCTION

Special Kids ♥ Special Care (SK/SC) is an approach to medical care coordination for children in foster care with special health care needs being pilot tested by the Massachusetts Division of Medical Assistance (DMA) in collaboration with the Massachusetts Department of Social Services (DSS) and Neighborhood Health Plan, a non-profit managed care organization that contracts with DMA. SK/SC was designed for children who have complex medical needs or unstable medical conditions and focuses on the whole child by addressing medical, behavioral health and developmental needs. SK/SC is different from other examples presented in this paper in that it incorporates a monthly capitated payment rate for each enrolled child and is managed by a managed care organization. We have included it in this study because it addresses integration of physical health and behavioral health care and demonstrates how a managed health plan can be used to ensure the delivery of comprehensive health care for children in foster care. The approaches used by Special Kids/Special Care are organized in this description by the following components:

- collaboration
- funding strategies
- screening and assessment
- coordination of care
- provider network
- monitoring and evaluation
- key features
- challenges

Special Kids ♥ Special Care

SK/SC was established in 1999 to help ensure that certain children with special health care needs in the custody of the state who live in foster homes have access to high-quality, well-coordinated, medically appropriate health care services. SK/SC will operate as a pilot program until July 2004. It currently serves 70 children.

In Massachusetts, most Medicaid consumers choose between two options to receive health services: 1) they can join a managed care organization (MCO) from which they receive all health and behavioral health/substance abuse services, or 2) they can participate in the DMA Primary Care Clinician (PCC) Plan for management of their primary and other health care needs while receiving behavioral health/substance abuse services through the Massachusetts Behavioral Health Partnership (MBHP or the Partnership), a capitated carve out program with shared risk. Many children in foster care who are eligible for Medicaid, receive services through the state's PCC Plan and the Partnership.

With the advent of SK/SC three or so years ago, the then-Commissioners from DSS and DMA agreed to focus on enrolling certain medically involved children living in foster care in a MCO. Neighborhood Health Plan, a MCO which contracts with DMA, was chosen as the MCO for these children because it administers a special program, Community Medical Alliance, which offers a special model of coordinated health care delivery for targeted individuals.

To be potentially eligible for enrollment in SK/SC, children must be in the custody of DSS, between the ages of birth and 22, living in foster homes at the time of enrollment, and need the following:

- complex medical management on a regular basis over a prolonged period of time, **and**
- direct administration of skilled nursing care requiring complex nursing procedures on a regular basis over a prolonged period of time, **or**
- skilled assessment or monitoring related to an unstable medical condition on a regular basis over a prolonged period of time.

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A pediatrician at DMA reviews recent medical records to determine the medical appropriateness of the child for pilot enrollment.

Each child enrolled in SK/SC has a pediatric nurse practitioner (employed by NHP) who co-manages (with other team members) the child's care. Children in SK/SC who need behavioral health services also receive these services through Neighborhood Health Plan. NHP contracts with a behavioral health clinician to help coordinate care for MCO members who have mental health, developmental, or substance abuse issues.

COLLABORATION

DSS, DMA, and NHP share in administering the program. DSS is the referral agency, DMA is the funding and contract managing agency, and NHP serves as the MCO for the program, delivering needed medical and behavioral health care to children enrolled in the pilot program. Two monthly meetings promote ongoing collaboration. One focuses on individual children and the other addresses program policies.

- **Case Review Team**—attendees include DSS social workers (often via phone) and administrators, NHP nurse practitioners and administrative staff, and DMA clinical and administrative staff. The Case Review Team focuses on the individualized care plans for each child and does a comprehensive review of the medical, developmental, behavioral and social needs of the children who are enrolled. Six to eight children are discussed at each meeting. When needed, these meetings occur twice a month.
- **Steering Committee**—attendees are administrators and clinical staff from the three collaborating organizations. This committee focuses on program, policy and procedures, and evaluation activities.

FUNDING STRATEGIES

DMA has established a limited no-risk capitated payment arrangement with its contractor, NHP, which is intended to meet the contractor's service costs for each child enrolled. This rate covers the administrative and service costs of the pilot program, including the employment of nurse practitioners and

medical and behavioral health services, as needed. The rate was based on a fee-for-service equivalent for children with like medical conditions/utilization.

SCREENING AND ASSESSMENT

The NHP nurse practitioners perform comprehensive assessments (which include behavioral health) on each child at the time of enrollment in SK/SC. Input and historical information from DSS and families are vital for the comprehensive assessment. The program looks at assessment as an ongoing process and continually reassesses a child's needs as progress is made and as circumstances change.

COORDINATION OF CARE

NHP provides a nurse practitioner for each child enrolled in SK/SC. Each nurse works with approximately 30 children at a time. In their role as care coordinators, the SK/SC pediatric nurse practitioners focus on tasks which include, but are not limited to:

- visits to the home when a child first enters the program, and on an ongoing basis, to perform sick and well child visits;
- developing an individualized health care plan for the child which is kept in the foster home and is distributed to all key members of the child's health care service team;
- 24-hour availability of the SK/SC pediatric nurse practitioner;
- authorizing services, medical equipment and supplies for the child and serving as a point of entry for any other services provided by the MCO;
- serving as a clinical resource and educator for foster parents, guardians and birth parents, school nurses, DSS staff and other significant people involved with the child;
- maintaining current and comprehensive health care information for each child;
- assessing the need for specialty care and assisting foster parents and DSS staff in arranging such services, when assistance is necessary;
- coordinating care with respite providers;

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- assisting DSS staff with medical components of transition back to birth parents or to adoptive parents and collaborating with DSS staff to assess the parents' abilities to provide care; and
- communicating with other stakeholders involved with the child, e.g., parents, caregivers, DSS social workers and supervisors, school nurses, primary care physicians, courts, early intervention and home health agency staff.

Nurse practitioners have the authority to order services, providing quick access to special care when needed. The nurse practitioners share information with all involved parties. They update individual care plans at least quarterly and send them to families, caretakers, providers, DSS, and DMA. The nurse practitioner often accompanies foster and birth parents on visits to the primary care provider. When needed the behavioral health clinician and nurse practitioner work closely together using an individualized care process to serve children with serious medical needs who also have challenging behavioral health issues.

PROVIDER NETWORK

NHP has a comprehensive network of providers available to its members. Each child in the Pilot program is followed by a primary care provider from the NHP Special Kids ♥ Special Care network. When a child first enters the program, if his/her current provider is not a part of the NHP SK/SC network, the provider is encouraged to join the network so that continuity of care can be maintained for the child. The primary care provider and the nurse practitioner lead the child's medical team.

Each child has access to specialists within the NHP network, but if the right provider is not available through the network, the nurse practitioner seeks authorization to go outside of the network for specialty care.

Communication among all the providers who work with each child is important. Behavioral health providers are part of this communication network, as needed. The nurse practitioner acts as the liaison, ensuring that each provider knows what the other is doing related to a child's care. Good working

relationships, the team model and strong support from the community-based nurse practitioners have been incentives for the participation of providers.

MONITORING AND EVALUATION

As a pilot program, SK/SC has a formal evaluation underway conducted by the University of Massachusetts Center for Health Policy and Research in collaboration with staff from DMA, DSS and NHP. A report is planned to be available in early summer 2003. The evaluation will include the results of interviews with foster parents of enrolled children, program staff from the three agencies, as well as relevant service cost and utilization data.

KEY FEATURES

- **Open, consistent, and timely communication**—The nurse practitioner and the behavioral health clinician (when she is involved) serve as primary liaisons for communication among all involved parties - the child, family, caretakers, the primary care provider and all other providers, DSS, DMA, and schools. **Clinical review team meetings** that occur at least once a month are an important means of communication. Frequent communication and collaborative treatment planning assist in integrating health care plans and DSS service plans that focus on safety, permanency and well being.
- **A team approach to primary and specialty care**—The nurse practitioner extends clinical decision-making and care into the child's home or alternative sites.
- **Empowerment of the primary care team**—The child's SK/SC pediatrician, pediatric nurse practitioner and behavioral health clinician have the authority to order services and allocate resources when and where they are needed.
- **Coordination is the model of care**—There is one person, the pediatric nurse practitioner, who coordinates care. An individualized care plan that is shared with all parties guides the treatment.
- **Flexible benefits**—Benefits that are responsive to the special medical, behavioral health, social and support service needs of each child serve as alternatives to hospital and institutional care.

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- **Access to a specialized network of providers**—The nurse practitioners can access specialty providers both through the NHP network and through providers outside of the network, when needed.
- **Collegial and collaborative relationships**—Building positive relationships among the contracting agency (DMA), the referring agency (DSS), and the managed care organization (NHP) has been one of the strong points of the program. There is a shared desire to help each other in making this work for children and families.
- **Continuity of care at transition times**—When a child is reunified with his/her own family or placed in an adoptive home, the nurse practitioners work with the birth or adoptive parents to help them understand the child's health care needs and to provide the information they will need to address all of the child's health care needs. If a child will be using different providers when no longer enrolled in SK/SC, the nurses help make the transition to the new providers.
- **24/7 on-call coverage by clinicians familiar with every child**—The SK/SC pediatric nurse practitioners provide 24/7 coverage for symptom management, management of ER visits and support for the foster parents.
- **Engaging multiple families in the care of one child**—For the children in foster care who are involved with their birth families, the nurse practitioners have had to learn how to work with birth and foster parents simultaneously. They have learned how to address visitation, coordination of care, and training in the child's specific health care needs from the perspective of both the foster and birth parents. Nurse practitioners often teach two families, and sometimes two or more social workers (DSS, contract foster care agency worker, child's mentor) about the child's health care needs.

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CHALLENGES

- **Start up issues**—While the agencies involved with SK/SC worked very collaboratively during the planning stages, there were start-up challenges to address. For example, prior to involvement of the NHP nurse practitioners, DSS social workers, DSS nurses, and foster parents had, on their own, been managing the care of children with very complex medical needs. The nurse practitioners were sensitive to the good work that had been done by others while demonstrating the value of the additional support, expertise, and coordination that they had to offer.

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ASSESSMENT AND CONSULTATION TEAM RIVERSIDE COUNTY, CALIFORNIA³⁴

In 1997 Riverside County began a new program between Department of Mental Health (DMH) and Department of Public Social Services (DPSS). It was called the Assessment and Consultation Team (ACT). This program provided access to Medicaid reimbursement through DMH for mental health services for children in the child welfare system. The program became a foundation for the managed care system implemented in the county for all Medicaid recipients later in the same year. The following summary provides a brief description of ACT and the approaches it uses to ensure behavioral health care for children in the child welfare system. The approaches are organized by the following components:

- collaboration
- funding strategies.
- access
- provider issues
- family focus.

ASSESSMENT AND CONSULTATION TEAM (ACT)

The ACT program was designed to:

- provide children and families served by DPSS with direct access to an expanded range of mental health assessment and treatment services
- monitor the quality and quantity of mental health services provided
- reduce local expenditures by billing Medi-Cal (California's Medicaid program) whenever possible.

ACT has placed 13 licensed mental health clinicians from DMH in DPSS offices throughout the county to initiate and monitor the process of obtaining coordinated mental health services for children referred to them by DPSS social workers. ACT clinicians are involved with approximately 3,000 children at any point in time. The children can be in foster care or living in their own homes and receiving

services from DPSS. Social workers refer children to the ACT clinicians who are responsible for:

- review and assessment of a child's need for mental health services
- direct clinical assessment of children served by DPSS whose clinical needs are unclear
- determination of treatment to be provided through county operated mental health clinics or to be authorized through the Mental Health Department's managed care plan
- initial referral/authorization for mental health services
- routine review of mental health treatment plans and authorization of requests for extension of services
- providing consultation to DPSS social workers regarding mental health issues related to the children served by DPSS.

Additionally, a full time clinician is utilized to provide clinical assessments within 30 days on all children ages 3 to 18, who live in shelter homes (initial placements when removed from their own homes).

COLLABORATION

In Riverside County, DMH and DPSS have historically engaged in interagency efforts to provide coordinated and joint services. Development of the Assessment and Consultation Team began in the summer 1997, just months before DMH became the managed care entity for behavioral health. ACT transitioned naturally into the managed care system when DMH became the formal access point for community-based mental health treatment services for children and adults involved with DPSS.

³⁴ The ACT in Riverside County, CA was studied under a separate project conducted by Georgetown University—*Meeting the Health Care Needs of Children in the Foster Care System*—funded primarily by the Maternal and Child Health Bureau in the federal Department of Health and Human Services. As part of that project, a site visit to Riverside County was conducted in the fall of 2000. Because ACT is based on the structure and resources of the behavioral health managed care plan in Riverside County, it is included also as a promising strategy in this study.

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Although DPSS and DMH took pride in their history of interagency collaborative efforts, tension existed because the mental health system had not been able to meet the needs of all children within the DPSS system. County mental health clinics were overloaded, and foster parents reported that it could take up to six months from the time they sought treatment for a child to the time when they would actually receive an appointment. Under pressure from the court system to access providers more quickly, DPSS was spending nearly two million dollars a year in child welfare funds to obtain mental health counseling services for children in foster care from community-based providers, many of whom were not authorized to receive Medi-Cal payments. Therefore, DPSS was faced with having to use county funds to cover the costs of their services. DPSS administrators reported that it was difficult for the agency to serve as a “gatekeeper” for these providers, virtually no treatment standards existed, and social workers had to resort to the phone book to find providers.

DPSS recognized that DMH, as the behavioral health managed care plan for the county, had the responsibility and the expertise to develop the provider network and to find and authorize appropriate services. Thus, DPSS and DMH entered into an interagency agreement that established the ACT team.³⁵ While traditional concerns about access to mental health services through some of the county clinics continue, collaboration around the ACT program has strengthened the relationship between DPSS and DMH.

In addition to accessing services for children, ACT clinicians listen to and support the DPSS workers, debrief difficult child and family situations, train new social workers (in mental health services and the ACT program) and participate in child protective services unit meetings. In the desert region, foster parents are able to reach ACT clinicians through a 24-hour warm line to discuss mental health issues. ACT is truly a collaborative effort with clinicians (employed by DMH) housed in DPSS offices and supported with Medi-Cal funds that are appropriated to DPSS (see funding strategies below).

FUNDING STRATEGIES

To fund the ACT clinician positions, DPSS prepared an application for administrative case management funding through Medi-Cal. County social services departments may fund licensed clinicians meeting the designation of Skilled Professional Medical Personnel (SPMP). Through this funding source, the clinicians may provide selected activities “to help children who are Medi-Cal eligible, including children in foster care and children seriously emotionally disabled (SED), to gain access to health related services in order to reduce their risk of poor health outcome.” DPSS was approved as the fiscal agent to receive the SPMP funds from Medi-Cal and is required to provide a 25% match to the total budget. If the clinicians were not licensed, the DPSS level of match would be 50%. DMH hires the ACT clinicians, but is reimbursed by DPSS for these costs.

As Skilled Professional Medical Personnel, the ACT clinicians are allowed to provide assessment and screening, but cannot provide direct treatment services through this funding source. Individual providers, who have contracted with the county DMH to be part of the managed care provider network, bill DMH for all services provided. DMH is responsible for paying providers for all reimbursable services and for billing Medi-Cal when allowable. DPSS reimburses DMH for all costs of services not reimbursed by other funding sources. DPSS also has agreed to pay for a maximum of 4 hours/week direct counseling services provided by the ACT clinicians.

Because almost all the services provided for children in foster care are Medi-Cal reimbursable, DPSS has reduced its costs for treatment services. However, if a parent or family member needs treatment and is not Medi-Cal eligible, DPSS funding can be used to fund services for family members. Respondents indicated that the first priority is to provide the service needed, and to later determine the appropriate funding source.

³⁵ The Scope of Work for this agreement, known as CART (Consultation/Counseling, Assessment, Referral, and Treatment Services) is available from the Georgetown University Child Development Center

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ACCESS

When a DPSS social worker believes that mental health treatment for a child might be indicated, s/he completes a referral form. Upon receiving a referral, the ACT clinician consults with the social worker and reviews available information about the child. If needed, the clinician will see the child and/or family for a mental health assessment (mental status exam, family history, and review of past mental health services).

ACT clinicians make referrals to a network of community-based providers or to a county mental health clinic within 10 to 15 working days after referral by the social worker. If the provider cannot see the child within two weeks of the referral, the clinician will seek another provider. (Children in crises are referred immediately.) The ACT clinicians attempt to match children with the most appropriate provider. Children with the most serious service needs are usually referred to a county mental health clinic for a comprehensive assessment and access to a wider variety of community-based services than individual private providers offer. Individual community-based providers receive authorization for three months. The standard package of services includes weekly individual therapy, and family therapy, if warranted. At the end of the three months, providers send a report to the ACT clinician who will determine with the DPSS social worker whether the child/family needs further services. Requests for extension of services are typically processed within three days.

Riverside County has created an extensive array of mental health services for children and their families, accessed through a variety of routes. The ACT clinicians are the access point and referring authority for **some, but not all** of these services. For example, if following consultation with the ACT clinician, a child or family member appears to need substance abuse services, parenting classes, or anger management, the social worker pursues these services through separate contracts that DPSS has for those services. If the child appears to need a higher level of placement, such as group homes, therapeutic foster care or residential care, the social worker goes to an Interagency Placement Screening committee, available several times

a week, to discuss special placement needs. These committees, consisting of social services and mental health placement specialists, plus education staff, determine the level of placement needed, the specific placement resources most appropriate, and any additional services needed.

Although ACT clinicians are primarily responsible for the assessments and referral services described, they can provide up to 4 hours per week in direct service. Clinicians in the desert region of the county feel that their smaller caseloads allow them to spend more face-to-face time with children and families, whereas ACT clinicians in the Riverside metropolitan and mid-county area spend the majority of their time consulting, processing referrals and contacting providers.

PROVIDER ISSUES

ACT clinicians make referrals to a network of community-based providers who can bill Medi-Cal for services. As a result of the Department of Mental Health's efforts to recruit and authorize providers for the Medi-Cal managed care network, the number of providers available to children involved with DPSS has expanded from approximately 50 to 350. This allows the ACT clinicians to make referrals to the "right" providers - those who specialize in the individual needs of specific children or families, rather than to just any provider who has an opening (as was often the case before ACT). Providers must send care plans, quarterly reports and discharge summaries on each child served to the ACT clinicians. ACT clinicians refer to the providers that they believe do the best work. They get to know the providers by using them and share information with each other about the providers.

FAMILY FOCUS

While the ACT clinicians are charged primarily with accessing services for **children**, they can initiate referrals for parents or other family members who need mental health services. Once such a referral is made, it becomes the parent's responsibility to seek the services. Riverside County DPSS assumes payment responsibility for mental health services for parents of children in foster care who are not Medi-Cal

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eligible. The operating philosophy is to provide the needed service, and then determine the most appropriate funding source. ACT clinicians are able to authorize services for children in their own homes, in relative placements, in voluntary placements, and in foster care.

KEY FEATURES

- **Co-location**—Working together in the same office is essential to making it work. When social workers and clinicians are housed in the same office, it improves attitudes and encourages informal conversations and information sharing. Social workers become more sophisticated about mental health issues, and clinicians understand the realities of the child welfare system and the families served. It provides the opportunity to offer mental health support to the social workers themselves.
- **Interagency relationships**—There is dedication on the part of both DMH and DPSS to make this work. They are willing to work through problems together. Support comes from top-level administrators from both agencies.
- **Clinical expertise**—The ACT program has brought clinical expertise to DPSS. The search for appropriate providers is in the hands of a mental health expert. Social workers and foster parents do not have to spend their time searching (often through the phone book) for treatment providers. Mental health care has become continuous, social workers are not responsible for reauthorizing care, and they no longer fear that children will slip through the cracks.
- **Important qualities**—Essential qualities for the ACT clinician are: knowledge of the community and its resources, thorough understanding of the county mental health managed care plan, strong communication skills, organizational skills, the willingness and ability to respond quickly and to consult with social workers as a colleague, rather than as an expert.
- **Access to services for other family members**—Even if they are not eligible for Medi-Cal and the county's managed care plan, parents and other family members must be able to access services. DPSS assumes this responsibility in Riverside County.

- **Services can be obtained promptly**—Children who are not in an emergency situation will be seen within two weeks. If a provider is not able to see them within that time frame, another provider is sought.
- **Creation of a strong provider network**—A community-based provider network supplements and expands the range of services available through the county mental health clinics. This fills what had been a gap in services - community-based care for children with moderate mental health needs. Providers must have the expertise to meet the special needs of children/families served by the child welfare system, and also the variety of cultures residing in the county.
- **Fiscal savings for DPSS**—The ability to bill Medi-Cal for services previously paid for by DPSS creates a fiscal savings for DPSS.

REMAINING CHALLENGES

- Access
 - The referral of a child for mental health services is dependent upon individual social workers. Some workers are more supportive of mental health services than others. Some rarely refer any child for services. The system has not yet created a structure for children and caregivers to self-refer to the ACT clinician.
 - While ACT ensures assessments for all children who are entering shelter care homes, respondents indicated the need for a system that also will ensure a mental health assessment for **all** children already in care. Discussion has been held about doing routine screenings, but this had not been implemented at the time of the site visit.
 - Access problems continue at some of the county mental health clinics. Comprehensive assessments are done in a timely manner, but there may be a long wait for treatment services.
- The search for appropriate providers in the rural (desert) and non-metropolitan areas continues to be difficult. The county needs more providers who speak Spanish and Vietnamese, and also more African-American providers.
- Transportation continues to be a problem in rural areas.

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- Court related issues—It remains a challenge to justify plans and recommendations to the court, where they may be overridden. Some judges are supportive of appropriate mental health treatment, some may order it inappropriately, and others rarely order it.
- Families—There are very few vehicles for families to provide input related to the ACT program. The system also needs policies about the role of families in their children’s mental health care. (This exists in county clinics, but is less clear in individual providers’ practice.) Family expertise is needed to pinpoint needed resources at the individual and system levels.
- While respondents noted the many benefits of ACT, it has been difficult to actually prove that the ACT program is cost effective and produces better outcomes for children and families.
- Recruiting and retaining ACT clinicians continues to be a challenge. Many clinicians want to provide more hands on treatment and direct services.

ADVICE

Respondents during the site visit had numerous recommendations and advice for other states or communities that might wish to develop a program similar to ACT.

- Place the clinicians in the DPSS offices. Co-location is very important.
- When initiating the program, choose people to be involved who are problem solvers, who will commit to work at it, to “think out of the box”—not just figureheads.
- It is important to have a point person, someone who is the liaison for each involved organization.
- Family expertise is needed at the table to pinpoint needed resources.
- Keep it simple, do not let the child and provider get lost in the complexity, e.g., getting lost in the managed care billing process.
- It is important to have a good computer system, one that is not too complicated.

- Clerical support is central to the program’s effectiveness.
- Provide clinicians with time to do some ongoing direct services also. This helps with retention. The ACT program uses DPSS funds for this, since the federal funding source used for clinician salaries does not allow for provision of ongoing direct services.
- It is easy to be seduced by the “paper”, e.g., if a provider provides good reports, but this does not necessarily mean s/he provides good treatment and vice versa.
- Training around mental health issues is important for social services staff.
- Provide mental health clinicians for social workers to deal with stress of their work.
- Be sure the provider network has an adequate number of providers of color and female providers, especially for girls who have been sexually abused.

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