HCRTP

Promising Approaches

for Behavioral Health Services to Children and Adolescents and Their Families in Managed Care Systems

7: Care Management in Public Sector Managed Care Systems

Mary I. Armstrong

USF
UNIVERSITY OF SOUTH FLORIDA

A Series of the

HCRTP Health Care Reform Tracking Project

Tracking Behavioral Health Services to Children and Adolescents and Their Families in Publicly-Financed Managed Care Systems

HCRTP Health Care Reform Tracking Project

Tracking State Managed Care Systems as They Affect Children and Adolescents with Behavioral Health Disorders and their Families

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Suggested APA Citation:

Armstrong, M. I., (2005). *Health care reform tracking project (HCRTP): Promising approaches for behavioral health services to children and adolescents and their families in managed care systems — 7: Care management in public sector managed care systems.* Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute (FMHI), Research and Training Center for Children's Mental Health. (**FMHI Publication #211–7**)

FMHI Publication #211–7

Series Note: HCRTP Promising Approaches – 7: Family Involvement in Managed Care Systems

First Printing: June 2005

This report was published by the Research and Training Center for Children's Mental Health, Louis de la Parte Florida Mental Health Institute, University of South Florida with funding from the National Institute on Disability and Rehabilitation Research, U.S. Department of Education and the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services grant **#H133B990022**, and the Administration on Children, Youth and Families, Administration for Children and Families, U.S. Department of Health and Human Services.

Research and Training Center For Children's Mental Health

National Institute on Disability and Rehabilitation Research

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services

Partial Contents: Introduction to HCRTP – Methodology for Promising Approaches Series – Overview PAS 7: Care Management in Publicly Funded Managed Care Systems (MCS) – Issues and Challenges – Coordination of Case Management/Care in Managed Care Systems – Impact of Managed Care on Care Coordination for High-Risk Children – Description of Promising Care Management Approaches – Child and Family Teams: Maricopa County, AZ – Coordinated Family Focused Care: MA – Child and Adolescent Continuous Treatment Teams: TN – Care Coordination Wraparound Milwaukee, WI – Service Coordination: The Dawn Project, Marion County, IN – Specific Background/Descriptions, Key Components, Eligibility Criteria, Involvement of Families/ Youth in Team Meetings, Staffing Requirements, Caseload Size, Reported Positive Impacts, Challenges and Problems, Fiscal Arrangements – Discussion – Policy and Practice Recommendations – Useful Resources – AZ Practice Improvement Protocol 9 – Availability of Reports and Analyses of the HCRTP – Order Forms for PAS 7 and Other HCRTP Publications

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June 2005

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Table of Contents

Page

Index of Tables

Page

HCRTP Health Care Reform Tracking Project

Tracking State Managed Care Systems as They Affect Children and Adolescents with Behavioral Health Disorders and their Families

Promising Approaches

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7: Care Management in Public Sector Managed Care Systems

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Introduction

Health Care Reform Tracking Project

Since 1995, the **Health Care Reform Tracking Project** (**HCRTP**) has tracked public sector managed care systems and their impact on children with behavioral health problems and their families. The HCRTP was conducted jointly by the Research and Training Center for Children's Mental Health at the University of South Florida, the Human Service Collaborative of Washington, DC, and the National Technical Assistance Center for Children's Mental Health at Georgetown University. The HCRTP was co-funded by the National Institute on Disability and Rehabilitation Research in the US Department of Education and the Substance Abuse and Mental Health Services Administration of the US Department of Health and Human Services. Supplemental funding was provided by the Administration for Children and Families of the US Department of Health and Human Services, the David and Lucile Packard Foundation, and the Center for Health Care Strategies, Inc. The mixed method design of the HCRTP Project included periodic surveys of all states; in-depth impact analyses involving site visits to a selected sample of states with experience in public sector managed care, and the identification and dissemination of promising approaches and features of managed care systems.[1]

Throughout these activities, the Tracking Project explored and compared the differential effects of **carve out designs**, defined as managed care arrangements in which behavioral health services are financed and administered separately from physical health services, and **integrated designs**, defined as arrangements in which the financing and administration of physical and behavioral health services are integrated.

[1] All reports of the Healthcare Reform Tracking Project (HCRTP) are available from the Research and Training Center for Children's Mental Health, Louis de la Parte Florida Mental Health Institute, University of South Florida, 13301 Bruce B. Downs Boulevard, Tampa, FL., (813) 974-6271. For a complete listing of HCRTP Publications see pages 43–46.

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Methodology for Study of Promising Approaches

The strategies and approaches that are described in the **Promising Approaches Series** were identified by key state and local informants who responded to the HCRTP's state surveys and who were interviewed during site visits to states for the HCRTP's impact analyses. Once promising approaches and features of managed care systems were identified through these methods, members of the HCRTP team, including researchers, family members, and practitioners, engaged in a number of additional methods to gather more detailed information about identified strategies within particular topical areas. Site visits were conducted in some cases, during which targeted interviews were held with key stakeholders, such as system purchasers and managers, managed care organization representatives, providers, family members, and representatives of other child-serving agencies. In other cases, telephone interviews were held with key state and local officials and family members to learn about promising strategies. Supporting documentation was gathered and reviewed to supplement the data gathered through the site visits and telephone interviews.

For each general topical area studied, a paper is prepared to explain the challenges and to describe promising approaches or features of managed care systems that are considered by key informants to improve service delivery for youth with behavioral health treatment needs and their families. These papers comprise the *Promising Approaches Series*.

The series intentionally avoids using the term, "model approaches." The strategies, approaches, and features of managed care systems described in the series are perceived by a diverse cross-section of key stakeholders to support effective service delivery for children with behavioral health disorders and their families; however, the HCRTP has not formally evaluated these approaches. In addition, none of these approaches or strategies is without problems and challenges, and each requires adaptation in new settings to take into account individual state and local circumstances. Additionally, a given state or locality described in the series may be implementing an effective strategy or approach in one part of its managed care system and yet be struggling with other aspects of the system.

It is important to note that the series does not describe the universe of promising approaches that are underway in states and localities related to each of the aspects of managed care systems that was studied. Rather, it provides a snapshot of promising approaches that have been identified through the HCRTP to date. New, innovative approaches are continually surfacing as the public sector continues to experiment with managed care.

Each approach or strategy that is described in the series is instructive in its own right. At the same time, there are commonalities across these strategies and approaches that can help to inform organizations of effective service delivery systems within a managed care environment for this population. An attempt is made in each paper to identify these commonalities, thus offering guidance to family run organizations, states and communities attempting to refine their managed care systems to better meet the needs of children and youth with serious behavioral health disorders and their families.

Overview

I. Promising Approaches 7: Care Management in Public Sector Managed Care Systems

As noted, each volume in the promising approaches series focuses on a specific aspect of publicly financed managed care systems. This paper focuses on promising approaches in care management for children with serious emotional problems enrolled in a managed care system and their families. The volume begins with a brief discussion of the issues and challenges related to care management within a managed care framework that have been identified through previous activities of the Tracking Project.

A number of promising approaches for care management are then described. Identified through the state surveys and impact analyses of the Tracking Project, these approaches are perceived by key state and local informants to support effective care management systems.

Issues and Challenges

Throughout the Tracking Project activities, stakeholders reported several barriers within managed care systems to serving children with serious emotional problems and their families, including the stringent application of medical necessity criteria, an emphasis on short-term treatment, and unintended financial incentives to underserve individuals with serious and complex needs. Key informants emphasized the need for managed care entities to incorporate special services and provisions for children and adolescents with serious emotional problems and their families. In the first *State Survey* (1995) produced by the Health Care Reform Tracking Project, only 44% of the systems reported including special arrangements for this high-risk population. The proportion increased slightly to 49% in the 1997–98 survey findings, perhaps reflecting the beginning of recognition of the needs of these youth and their families. The *2000 State Survey* showed a dramatic increase in the inclusion of special provisions, with a shift to 93% of the systems indicating that they did have special arrangements and services. The *2003 State Survey* found a 12% decrease, but the majority of managed care systems (81%) continued to include special provisions of some type.

The increases noted above in special provisions for high-risk children and youth and their families may be related to the growth in discrete state planning processes for special populations in managed care systems. Between 1997–98 and 2003, there was a reported 17% increase in the percentage of systems with discrete planning for this population. By 2003, three-fourths (74%) of states were engaged in a distinct planning process for children with serious emotional problems who were enrolled in managed care systems.

Coordination of Care Management in Managed Care Systems

Intensive case management was one of several special mechanisms reported by managed care systems as a strategy for serving children with serious emotional problems and their families. As shown on **Table 1**, by 2003 all the managed care systems who reported the use of special provisions included intensive case management as a strategy. The findings in **Table 1** reflect the pattern found throughout the Health Care Tracking Project of a greater likelihood of finding special provisions in managed care systems with carve out designs, defined as arrangements in which behavioral health services are financed and administered separately from physical health services, than in those with integrated designs, defined as arrangements in which the financing and administration of physical and behavioral health care are combined.

Table 1.

Type of Special Provisions Included by Managed Care Systems with Special Provisions for Children and Adolescents with Serious Behavioral Health Disorders

	1997–98 Total	2000 Total	2003			Percent of Change 1997/98–2003	Percent of Change 2000–2003
			Carve Out	Integrated	Total		
Expanded service array	90%	79%	84%	86%	85%	-5%	6%
Intensive case management	86%	86%	100%	100%	100%	14%	14%
Interagency treatment and service planning	57%	86%	100%	57%	88%	31%	2%
Wraparound services/process	71%	57%	95%	86%	92%	21%	35%
Family support services	67%	79%	84%	57%	77%	10%	-2%
Higher capitation or case rates	38%	29%	21%	57%	31%	-7%	2%
Flexible service dollars	Not Asked	Not Asked	58%	29%	50%	NA	NA
Other	0%	21%	5%	14%	8%	8%	-13%

NA=Not Applicable

Along with intensive case management, as might be expected, a majority of the managed care entities reportedly offered interagency treatment planning and service planning (88%), a substantive increase from 1997–98 when only slightly more than half of the systems (57%) offered this service. In addition, 92% of the managed care entities include wraparound services, although only half indicated that flexible service dollars were available to purchase wraparound services and supports. Finally, less than one-third (31%) incorporate higher capitation or case rates for children with serious emotional problems.

Impact of Managed Care on Care Coordination for High-Risk Children

Despite the reported growth in special provisions for children with special needs, the Tracking Project's impact analyses studies yielded conflicting results regarding the effect of managed care on care coordination for these youth and their families. In some states, managed care reportedly expanded the provision of case management services, whereas in others case management was reported to have been constricted as a result of managed care. Reasons given were the need for authorization and greater emphasis on utilization management than on accessing and coordinating care.

Given these conflicting findings, the 2000 and 2003 state surveys specifically investigated the effects of managed care on case management and care coordination. As shown in **Table 2**, both surveys found that in most systems care coordination had increased in comparison with pre-managed care.

Table 2.

Effect of Managed Care Systems on Case Management/Care Coordination Services for Children and Adolescents with Serious Behavioral Health Disorders

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Increased case management/care coordination	71%	82%	21%	58%	-13%
Decreased case management/care coordination	6%	0%	8%	3%	-3%
No effect	23%	18%	71%	39%	16%

It is interesting to note that the percentage of systems that reportedly had increased care coordination decreased from 71% of systems in 2000 to 58% of systems in 2003, and that the increase was much greater in carve outs (82%) than in integrated systems (21%) in 2003.

II. Description of Promising Care Management Approaches

As noted, promising care management approaches within managed care systems were identified through the Tracking Project's state surveys and impact analyses. Descriptive information on these approaches was obtained through three methods:

1. A **site visit** to Tennessee involving semi-structured interviews with key stakeholders in various communities;
2. **Telephone interviews** with key stakeholders in Arizona, Massachusetts, Milwaukee, and Indianapolis; and
3. **Review of documents** on all of the identified approaches.

The care management approaches share many common features, in both their design and operation. For each approach, key components and features, the role of families and youth in team meetings, eligibility and discharge criteria, financing arrangements, positive impacts, challenges and recommendations to other communities are described.

• Child and Family Teams: Maricopa County, AZ

Background and Description

The state of **Arizona** has an 1115 waiver that allows for the enrollment of Medicaid eligible persons in a statewide system of health plans. The state Medicaid agency, Arizona Health Care Cost Containment System (AHCCCS), contracts with the Arizona Department of Health Services' Division of Behavioral Health Services to operate a behavioral health care carve out for mental health and substance abuse services. The Arizona Department of Health Services also receives federal block grants and state appropriations for the public mental health system. Regional Behavioral Health Authorities (RHBAs) operate as capitated managed care entities. The RHBAs must cover services in nine domains (treatment, rehabilitation, support, medical, crisis, inpatient, prevention, residential, and day treatment). Individuals able to offer the services include behavioral health paraprofessionals who can provide support services such as respite, behavior support, and family support, technicians, and clinical professionals. Provider Types include Community Service Agencies and Therapeutic Foster Care families. The Regional Behavioral Health Authority in Maricopa County is ValueOptions.

The development of Child and Family Teams in Maricopa County has been a joint effort of ValueOptions, the Arizona Department of Health Services, and the Family Involvement Center, a parent-run resource and training center focused on children with behavioral health needs and their families. The initiative began as a pilot with 200 children with serious emotional problems. By March 2005, ValueOptions had 16,000 enrollees under the age of 18, and there were more than 2300 functioning teams operating under the auspices of ValueOption's seven subcontracted Comprehensive Service Providers. The mandate of the Arizona Department of Health Services is that the Child and Family Team approach will be effectively implemented for all 32,000 children served by the state of Arizona.

Child and Family Teams are guided by a specific Practice Improvement Protocol that includes a set of non-negotiable elements, commonly referred to as the Twelve Principles of the Arizona Vision[2]:

- **Strengths and Needs-Based Planning**. The expectation is that a strengths and culture discovery will be completed for each child and family, serving as the foundation for treatment planning. All services should be customized to creatively reflect the child and family's unique culture and individual strengths in addressing the behavioral health needs of the child.
- **Partnerships with Families**. All plans must include identified strengths and address identified behavioral health needs of child and family. Professional team members must be active partners with family members, ensuring that all agreed-upon plans reflect their values, priorities, strengths, and needs. An initial goal of the process is to assist the family in discovering and articulating these factors.

[2] Practice Improvement Protocol 9: The Child and Family Team on-line at: http://www.azdhs.gov/bhs/guidance/cft.pdf (for printed version see **Appendix A**).

- **Consensus**. All teams strive to reach consensus on needs, findings of assessment process, and service plan.
- **Jointly Established Service Plan**. When children have multi-agency, multi-system involvement, the assessment and service plan are jointly established and collaboratively implemented.
- **Natural and Informal Supports**. Teams are encouraged to have memberships that are at least 50% natural and informal supports.
- **Collaboration**. Cooperation is sought from other involved agencies, and from the community at large. When children and families are involved with multiple systems, collaboration demands the team's full respect for the societal mandates of each involved system.
- **Ongoing Assessment**. The underlying needs and strengths of each family must be continually reassessed and addressed on an ongoing basis. The assessment process, including the Strengths and Culture Discovery, is a continual, evolving course of action, and treatment planning an ongoing process.
- **Child and Family Team Participation in All Decisions that Affect Them**. Providers must by necessity be able to interact, communicate, and consult in the absence of a team. However, decisions affecting substantive changes in service delivery should not be made without the participation of the full Child and Family Team.
- **Crisis Planning**. The Child and Family Team develops a crisis plan that predicts the most likely worst case scenario, which includes strategies intended to prevent or mitigate that scenario, and a specific plan for what will happen if the crisis occurs. Crisis planning incorporates family, friends and natural supports, as well as formal supports if necessary.
- **Flexibility that Avoids Redundant Processes**. Child and Family Teams must be flexible, and when necessary adapt their processes to accommodate parallel processes like child welfare family decision making or permanency planning and Individualized Education Plan meetings in special education.
- **Single Point of Contact**. One member of the team is assigned as the single point of contact, and assumes responsibility for coordinating information exchange among Child and Family Team members and providers.
- **Cultural Competency**. The Child and Family Team should be culturally competent and linguistically appropriate, building on the unique values, preferences and strengths of the child and family and their community.

Eligibility Criteria

At the time of this study, the Child and Family Teams focused on children and families with the most complex needs, such as children in out-of-home placements, multi-system involved families, or children whose service plans have been unsuccessful. A child does not need to meet the criteria for serious emotional disturbance.

The intent is to extend the Child and Family Team process to every child enrolled in the mental health system by 2007. During 2005 Child and Family Teams are being developed in Maricopa County to fully support half of the children ValueOptions serves, including as priority populations all enrolled children involved in the child welfare and Adoption Subsidy programs, who are leaving juvenile detention or correctional settings, and those in any out-of-home care settings; plus any other children and youth who are identified (e.g., by families, other child serving systems, or through initial or ongoing behavioral health assessment) as at risk of out-of-home placement. "The Team identifies the underlying needs of the child (and of the family in providing for the child) and describes the type, intensity, and frequency of supports needed. As long as decisions are based on comprehensive reviews of the strengths and needs of the child, are concordant with the Twelve Principles of the Arizona Vision,[3] and have objective and measurable outcomes, then based on the recommendations of the team, the behavioral health representative secures any and all covered services that will address the needs of the child and family. The Child and Family Team is expected to carefully consider and give substantial weight to family preferences in formulating its views on the developing service plan, acknowledging the family's expert knowledge of their child."

Staffing

The Child and Family Team includes, at a minimum, the child and his/her family, any foster parents, a behavioral health representative, and any individuals important in the child's life and who are identified and invited to participate by the child and family. This may include teachers, extended family members, friends and other natural supports, coaches, community resource providers, and representatives from other child serving systems. The size and intensity of involvement of team members are determined by the objectives established for the child.

In Maricopa County, families have access to a Family Support Partner (FSP) who acts as a co-partner with the team facilitator. The FSP acts as a bridge-builder for the family, and builds respect for the family voice within the team. The FSP helps the family to identify its needs, including non-traditional, informal supports. The Family Involvement Center recruits and screens the Family Support Partners, but they are hired by the Comprehensive Service Providers who host the Child and Family Team process. The Family Involvement Center has coaches who offer follow-up support and technical assistance for the community providers, the Family Support Partners, and the supervisors of the Child and Family Teams. The pay level of Family Support Partners originally was the same as that of case managers, but some providers have raised the salary of case managers due to recruitment problems.

Every Child and Family Team has a Clinical Liaison, a behavioral health technician or professional who has met credentialing and privileging standards. Their responsibilities are to support the family, to facilitate the assessment process, to coordinate with the child's health care provider, to provide clinical expertise and consultation to the team, and to advise the team on services, supports, and providers of potential benefit to the team.

[3] Practice Improvement Protocol 9: The Child and Family Team on-line at: http://www.azdhs.gov/bhs/guidance/cft.pdf (for printed version see Appendix A).

ValueOptions and statewide, the Arizona Department of Health Services, have made a considerable investment in training the Child and Family Teams. Representatives from the Family Involvement Center along with ValueOptions personnel, co-facilitate all training on Child and Family Teams. Case managers and Family Support Partners receive training together during a two-week course. The Clinical Liaisons receive four days of training on team facilitation.

Quality Assurance Activities

The Child and Family Team process in Maricopa County is guided by a local Steering Committee, the Maricopa County Collaborative, representing family members, the child welfare, juvenile justice, developmental disabilities, and education systems, alongside behavioral health. There are two sub-committees, one that focuses on assessment and outcomes, and a second that identifies and addresses barriers. The Assessment and Outcomes Subcommittee, when focusing on the individual/case level, deploys family members and system partners who volunteer to conduct in-depth interviews of a sample of Child and Family Teams, based on the elements of the Wraparound Fidelity Index, Version 3.0. Families, team facilitators, family support partners, the child and other targeted team members have opportunities to share their experiences of the team process. Their results are analyzed and reported. Concomitant chart audits are beginning to complement those interviews. Feedback from these quality management processes is then shared with the individual Comprehensive Service Provider, with the expectation that efforts to improve practice occur, when indicated.

Caseload Size

For children with complex needs, the recommended caseload size is between 1:12 and 1:15, and does not exceed 20 children per case manager. The current rapid expansion of the Child and Family Team process to children with less complex needs will be instructive in determining team facilitation workforce requirements. Many willing family members are taught to facilitate their own Child and Family Team process over time.

Involvement of Families/Youth in Team Meetings

As noted earlier, one non-negotiable is that no decision of the Child and Family Team is made without the approval of the parent or guardian, and, when appropriate, of the child/adolescent. The expectation is that families will actively participate in the process of assessing needs and strengths, identifying team members, and developing and implementing the plan. No meetings that result in decisions affecting the child and family should occur without the family's full participation.

Discharge Criteria

The Child and Family Team process does not end until the child is disenrolled from services or transitioned to the adult system. Before discharge, a crisis plan is developed that outlines the specific steps to reconvene the team and re-establish services and supports, if necessary.

Reported Positive Impacts

Interviewees identified a number of positive changes that have occurred as a result of the Child and Family Team process. First, the behavioral health workforce is changing with the addition of paraprofessionals who serve as mentors, coaches, behavioral aides, parent education, etc. Second, service plans expand in scope as the use of informal, community resources is optimized. Improvements were noted in the assessment process, such as strengths-based and family-driven. Third, the adoption of a unified service planning process results in more congruent service planning across the various child serving systems. A cross-system perspective has created some new service modalities, including Urgent Behavioral Health Response, a service provided to youth entering foster care beginning within 24 hours of their removal and protective placement.

Family voice is another positive result of the Child and Family Team process. Previously, the professionals often decided what the child and family needed and would receive, rather than a team that uses a strengths-based discovery process to have the family identify what it wants and needs. “We believed that we had it before, but had no idea what it really meant”.

Challenges and Problems

One challenge is an existing workforce within children’s mental health providers who are used to behaving in a certain manner and may be resistant to new ways of interacting with children with mental health problems and their families, and with representatives from other child-serving systems.

ValueOptions’ providers compete with other child-serving systems for direct service staff, such as case managers, and for support services, including respite. Competition for these scarce resources makes it difficult to offer flexible services at the time and in the manner desired by families. A related problem is the turnover rate of case managers and other direct service providers, associated with inadequate salaries, supervision approaches in need of development (underway), and the challenge for some in making requisite attitudinal shifts from more traditional practice approaches to the Child and Family Team process.

A challenge for the Family Support Partners is the tension created by working for a provider, and carrying out the roles of advocate for families in the Child and Family Team Process and of family voice on policy and management advisory groups and working committees.

A final challenge noted is fidelity to the Child and Family Team process, and the related need for fiscal resources for training, coaching, and other quality assurance and quality improvement mechanisms, such as interviews with families and youth being served by Child and Family Teams. A standardized set of quality improvement supervision tools, practice fidelity methods and outcomes is scheduled for statewide implementation in 2005.

Fiscal Arrangements

The Arizona Department of Health Services (ADHS) has developed a technical assistance document supporting the Child and Family Team Process, including an Encounters/Billing Codes Matrix that outlines the nine steps and related activities that make up Arizona's Child and Family Team process (http://www.azdhs.gov/bhs/guidance/cfttad.pad). For each step and activity, the document identifies possible Medicaid billable codes that can be used for reimbursement. In addition to billing for the team process activities specified on ADHS' matrix, transportation, flex funds, and other covered services in the benefit plan may be used for services and supports designated in the child's service plan.

• Coordinated Family Focused Care: MA

Background and Description

The state of **Massachusetts** has a 1115 waiver that includes both a Primary Care Clinician Plan and a behavioral health carve out, the Massachusetts Behavioral Health Partnership. The Coordinated Family-Focused Care (CFFC) program is a service offered by the Massachusetts Behavioral Health Partnership. Currently CFFC is operating in five communities in Massachusetts: Brockton, Lawrence, New Bedford, Springfield, and Worcester. Its purpose is to provide individualized, family-focused, coordinated care to children and youth with serious emotional disturbance and their families. Through providing support to the youth and their families, the program reaches its goal of maintaining children in the community and reducing or eliminating the need for acute or residential treatment.

The mission of CFFC is to support children and adolescents with serious emotional disturbance by building upon child and family strengths and available support systems in order to maintain and improve the child's ability to remain and function productively in the community. The CFFC goals are to:

- Improve child functioning
- Appropriately increase tenure in the home or community setting
- Appropriately reduce the use of inpatient services and/or long-term residential services
- Increase school attendance
- Increase school performance
- Increase social supports and socialization
- Reduce involvement with the juvenile justice system
- Achieve parent and youth satisfaction with CFFC
- Foster the family's sense of competency in parenting a child with serious emotional disturbance

The CFFC values are based on the principles and values of systems of care (Stroul & Friedman, 1986). The program is committed to developing services that are child-centered, family-focused, community-based, multi-system, culturally competent, and least restrictive/least intrusive. In addition to the system of care values, CFFC adds the following values:

- Families are the most important caregivers
- All families and children have strengths that must be identified and emphasized
- Service system professionals have knowledge, skills, and strengths that are helpful to children and families
- There should be one coordinated plan of care for a child, incorporating all services and supports, including services provided or funded by state agencies.

The governance structure for CFFC includes a statewide steering committee and local committees for each CFFC site. The steering committee has responsibility for the implementation, quality management, training, and evaluation. The committee is comprised of representatives from state child serving agencies, the Massachusetts Behavioral Health Partnership, and two family organizations, the Federation for Children with Special Needs and the Parent/Professional Advocacy League.

Each local committee is co-chaired by a local committee member and the partnership's regional director. Local committees assist with quality management activities, community resource monitoring and development, family-specific issues or themes that indicate access and care coordination challenges, and public relations.

The quality assurance process for CFFC includes a set of indicators, training providers on the use of the Wraparound Fidelity Index, and periodic observations of team meetings. In addition, Consumer Quality Initiatives, an independent firm, interviews both families in the program and those that have been discharged.

The Massachusetts Division of Medical Assistance has contracted with the University of Massachusetts to conduct an evaluation of the effectiveness of CFFC. The evaluation uses a set of standardized instruments to measure child and family outcomes:

- The Child and Adolescent Functional Scale or the Preschool and Early Childhood Functional Assessment Scale
- Behavioral and Emotional Rating Scale
- Youth Outcome Questionnaire
- Parental Stress Index

Eligibility Criteria

The eligibility criteria for enrollment to CFFC are that a child be a member of the Mass Health and enrolled or eligible to be enrolled in the Massachusetts Behavioral Health Partnership, ages 3 through 18 or up to 22 if receiving special education services; residing at home and at risk of out of home placement or currently in out-of-home placement and able to return to a home environment with appropriate services and supports, and meets the criteria for the federal definition of serious emotional disturbance. In addition, the child must have a total score of 100 or higher on the Child and Adolescent Functional Assessment Scale (CAFAS) or the Preschool and Early Childhood Functional Assessment Scale (PECFAS).

Key Components of Child and Family Teams

Child and family teams provide services through a wraparound planning process that results in an individualized plan for the child and family. Each team includes a care manager and a family partner. CFFC defines wraparound as a philosophy of care that includes a planning process involving the child and family, and resulting in a unique set of community services and natural supports individualized for the child and family.

The care manager is responsible for the development and management of the care plan, and works with the family to determine membership of the care planning team. Members of the team may include the child and family, the care manager, the family

partner, school personnel, relatives, primary care physicians, clergy, professionals providing services to the child, and others identified by the family. The goal is that at least 50% of the team members will be family members and community representatives.

The assessment process (Intensive Care Planning) emphasizes the life domains of school/work, cultural and spiritual, social, safety and legal issues, health, emotional/psychological and recreational. Its purpose is to identify the child, family, and team strengths and needs that can be used to guide the wraparound planning process.

The family has the right to say what they want, and has the lead role in the development of the individual care plan. Care planning uses the findings of the strengths discovery process and goals prioritized by the family. The plan includes both formal services and informal services from the family's support system, with the expectation that about half of the supports and services will be from informal supports or other community resources. As needed, specific plans are such as a behavioral management plan or a crisis prevention and response plan. In addition, each plan addresses integration with primary care physicians regarding health and medical needs, and coordination with the Individual Education Plan (IEP), and other state agency involved services.

The care plan includes an individualized array of care management and support services, including:

- Individualized and family-focused interventions and supports
- Behavior management plans and supports
- Education and support for family members
- Links between family, school, community resources and natural supports
- Facilitation of a positive relationship between the child/family and staff/resources of the child's school
- Advocating with the family to the school for needed special education and school resources
- Identification of after-school community resources and therapeutic programs
- Assistance to family, as needed, to access public services

The CFFC team facilitates linkage to and coordination with clinical services, such as emergency services, diagnostic evaluation, individual, group, family therapy, medication evaluation and management, and inpatient care. Each team has flexible funds; their utilization must be based on a need and tied to a goal for the child and family. The use of flexible funds should be coupled with the work of the CFFC provider and local committee to identify and develop natural supports.

CFFC teams are available 24 hours a day, seven days a week to families in the program, through a shared rotation among the care managers. Services available include telephone support, on-site support if needed, access to in-home crisis respite and referral to other Partnership services if the crisis cannot managed through CFFC resources.

Staffing

Each CFFC site has five full-time care managers, one of whom is a senior care manger, and five full-time family partners, one of whom is a senior family partner. The care managers and family partners are paired in teams to service approximately ten families each, for a total of 50 families at each site.

The care manager is a team member who provides care management, crisis planning and intervention and therapeutic supports. A care manager is a Master's level licensed clinician, or Master's level licensed eligible clinician with at least five years of experience in providing outpatient behavioral health services to children and families. The family partner is a CFFC team member who provides support, advocacy, and education to families enrolled in the CFFC program. A family partner is currently or has been a parent of a child with a behavioral health need. The family partner must have experience working collaboratively with state agencies, schools, consumer advocacy groups, and /or behavioral health outpatient programs.

Each CFFC provider has the following staff to support the five teams:

- Full-time program director
- Senior family partner, who functions as a family partner, and supervises the other four family partners
- Full-time administrative assistant
- Child/adolescent psychiatrist, 3.2 hours of consultation per week.
- Senior care manager who functions as a care manager and supervises the other four care managers

Caseload Size

According to the CFFC program standards, each CFFC team (case manager and Family Partner) is responsible for coordinating care for ten children and their families. Thus far, the program is operating at this caseload level. One related challenge is that even though the commitment is to the family, Medicaid funding requires that the child, rather than the family, is enrolled.

Involvement of Families/Youth in Team Meetings

The care planning team for each child includes the child and family, professionals, advocates, and family supports who together develop and implement an individualized care plan. The expectation is that family members and natural supports should comprise at least 50% of the Care Planning Team. The individual care plan is the primary coordination tool for therapeutic interventions and wraparound planning, and the family has the lead role in its development. The plan is guided by the information gathered through the strengths discovery process and the family's goals.

Key stakeholders reported that parents typically do attend team meetings and decide who comes to the meeting. The youth can attend, depending on their age and desire to participate in the meeting.

Each CFFC provider is expected to develop and facilitate family support activities for parents, families and children which may include peer support groups, psycho-educational activities, guest speakers or recreational/social activities. For example, one site holds a Family Night each Wednesday evening. This informal event gives family members an opportunity to network with one another, and to touch base with their care manager and family partner.

Discharge Criteria

There is no time limit for enrollment in the program. Discharge is determined by the family and care plan team. Discharge criteria include:

- Individual Care Plan and discharge goals have been substantially met
- Treatment goals require other levels of care
- Discharge is considered when a child is placed in a placement expected to continue for more than 4–6 weeks
- Child is no longer a member of MassHealth
- Parent/guardian withdraws consent or refuses to participate in CFFC
- Child reaches age 19 (or age 22, if receiving special education services)
- Child/family no longer lives in one of the five communities.

Reported Positive Impacts

One perception was that CFFC has provided the framework for a dialogue about how we should be working with families with schools, the child welfare system, and providers. Reportedly, all systems are thinking differently about how they should be working with families, and are talking to families differently. There's a growing realization that the medical deficit-based model, and a culture of blaming and disenfranchising families are not productive.

Based on the family interviews conducted by Consumer Quality Initiatives, families believe that CFFC has been exceptionally helpful to them.

Challenges and Problems

One challenge is staff recruitment and retention. The initial plan was to hire experienced Master's level clinicians as case managers. Due to the problems with finding individuals, the criteria was changed to new Master's level graduates. Similar problems have occurred with the recruitment of Family Partners; criteria have been revised to families with children with serious medical or behavioral health needs.

Another challenge is that because this program is currently supported as a state-funded multi-year pilot, the program managers feel a pressure to be successful immediately.

Fiscal Arrangements

The CFFC pilot is funded by the state Departments of Mental Health, Social Services (child welfare), Youth Services (juvenile justice), Education, and Medicaid. Each state department has committed funds for three years, during which the pilot will be evaluated. In addition to state funding, the state receives a grant from the Center for Health Care Strategies (CHCS). This three year grant, totaling approximately $700,000, funds the evaluation of the CFFC pilot, initial costs for a coordinator to oversee start-up of the initiative, and training for the providers.

• Child and Adolescent Continuous Treatment Teams: TN

Background

The state of **Tennessee** has an 1115 waiver. TennCare Partners is a state wide program that covers Medicaid eligible individuals as well as the uninsured population. The state contracts with Premier Behavioral Systems and Tennessee Behavioral Health. The contracts are managed by AdvoCare of Tennessee, a division of Magellan Health Services, to provide a behavioral health carve out. AdvoCare is paid a capitated rate on a per member/per month basis.

AdvoCare supports two models of intensive case management for children with serious emotional problems and their families: Child and Adolescent Continuous Treatment Teams (CTT) and Comprehensive Child and Family Treatment (CCFT). Both models are implemented by multidisciplinary teams, provide services 24 hours a day/seven days a week, are strength based, and emphasize active family involvement. However, CTT is intended to provide longer term, comprehensive rehabilitative services whereas CCFT is time-limited, crisis oriented, and aimed at short-term stabilization. CTTs provide a range of services including crisis intervention and stabilization, counseling, skill building, therapeutic intervention, advocacy, medication management, and school-based counseling.

CTT was initially implemented in March of 2000. CTT services are now provided by teams within 18 Community Health Agencies (CHAs) across the state of Tennessee. At the time of the study, 500 slots were funded and there were no waiting lists for services.

Eligibility Criteria

CTT targets youth with serious emotional disturbance who are covered by TennCare and their families. The child must have a major mental health diagnosis and be at risk of out-of-home placement. The length of stay in CTT was four to six months at one community health agency, and seven months to one year at another site; it is unusual for a child to be enrolled in CTT for over a year.

Key Components

The goal of CTT is to support the child and family in natural environments such as home, school, and community. The CTT model is similar to a wraparound process except that flexible funds are not included. Key components of CTT are the use of a team approach, building supports for the child and family, linking the child/family with needed services and community resources, educating families on mental illness and treatment components, and strong involvement with schools when the child has behavioral problems.

Service intensity is another key component of CTT. When the model was originally implemented, CTT case managers were expected to provide 16 hours per month of direct face-to-face services with each child and family, with a minimum of eight hours delivered in the home and 12 hours delivered in community settings. Based on outcome evaluations and the need to facilitate flexible, youth and family-driven service planning, this standard

has been reduced to 12 contacts per month. When a child is being transitioned to regular case management, the standard specifies at least eight contacts per month for a two-month period.

Another key feature of CTT is team-based treatment planning and review. Teams meet weekly to review children's treatment plans and progress. Although youth are assigned a primary case manager, they frequently meet and receive some services from other team members, including the team leader. The nurse practitioner, for example, reviews the use of psychotropic medications. Therapists and nurses participate in weekly team meetings. Case managers often seek their peers' input on treatment issues.

AdvoCare has contracted with an independent evaluation consultant, to conduct a longitudinal process and outcome evaluation of the Continuous Treatment Teams. This process has lead to multiple quality improvement opportunities and supports evidence-based decision-making and practice. For this evaluation, case managers collect on a monthly basis, youth functioning data such as school status, housing, legal system involvement, and global functioning. They also complete measures of youth symptoms and functioning every three months. A final component of the evaluation assesses youth and family perceptions and program fidelity. AdvoCare has a subcontract with Tennessee Voices for Children to interview youth and family members regarding their perceptions of CTT services using the Wraparound Fidelity Index (Version 2.1).

Staffing

Multidisciplinary teams (including therapists, psychiatrists and nurse practitioners), provide a range of services including crisis intervention and stabilization, skill building, therapeutic intervention, advocacy, medication management, and school-based counseling. For example, at one Community Health Agency with six teams serving 36 children and their families, the CTT staffing was one team leader, six case managers, a nurse practitioner, a child psychiatrist, and an administrative coordinator. The catchement area of the center is seven rural counties; each case manager serves a designated geographic area.

Services are available 24 hours a day, seven days a week. Reportedly case managers are rarely called during off hours because there are extensive contacts with the child, and crises can be predicted and prevented. In addition, safety plans are completed with families so that a plan is in place for when crises do occur.

The qualification for case manager is a bachelor's level degree in human services. The starting salary for case managers is $24,000–$25,000, depending on previous experience. Supervisors must have a master's degree, a license in human services, and at least one year of experience.

Caseload Size

Although the number of case managers may vary by CMHA, each CTT team includes at least four case managers one of whom is the team leader. Each CTT case manager serves no more than six children and their families. The perception is that the small caseload makes it easier for CTTs to be more accessible to families, to concentrate on skill building in the child's daily life, and to advocate with schools.

Involvement of Families/Youth in Team Meetings

Reportedly family involvement is much stronger in the assessment phase in CTT than in regular case management. After the assessment, the case manager and the family plan and set up treatment goals; the family and the child sign the treatment plan.

At one community health agency, both the child and the family are invited to attend or participate regularly in the initial assessment and service planning meetings. At the other site, families and children typically do not participate in case staffings. Barriers to family participation include lack of transportation options, parents' work schedules, and parents sometimes feeling intimidated by the other team members.

Discharge Criteria

The guidelines for discharging a child/adolescent from the CTT program are satisfied by meeting criterion one (the applicable elements), criterion two, three, or four as follows:

1. Risk factors have been minimized as evidenced by each of the following:
    a. The child/adolescent has not been hospitalized in an acute psychiatric setting or had a RTC or IRT placement within the past six months.
    b. The child/adolescent's functioning level has improved to the extent that CTT services are no longer required to ensure the continuation in a community setting.
    c. The child/adolescent's level of functioning is adequate to anticipate safety and stability within the community either independently or with the assistance provided by a less intensive or standard Mental Health Case Management.
    d. The child/adolescent has not required crisis services or an emergency response in the past three months.
    e. The child/adolescent has had a period of at least three months during which substantial changes or adjustments in medication have not been needed.
    f. The child/adolescent has had a period of at least three months during which his/her living arrangement has remained stable and unchanged.
    g. The child/adolescent's family support system has been substantially strengthened.
    h. The majority of the goals in the child/adolescent's service plan have been met.
2. The child/adolescent does not meet the Continued Stay Guidelines.
3. The child/adolescent's length of stay in an acute psychiatric setting, RTC, or IRT exceeds 30 days. Continued stay in CTT while the child/adolescent is in one of these therapeutic settings beyond 30 days requires special approval by AdvoCare Care Management Staff.
4. The child/adolescent and/or family are noncompliant with treatment despite repeated attempts by the CTT team to actively engage/involve the client/family in the program.

There is some flexibility in length of stay based on individual clinical needs. Teams reported no pressure to discharge children within a certain timeframe and lengths of stay vary considerably within and across teams.

Reported Positive Impacts

At the system level, the evaluation has demonstrated that the CTTs have reduced the use of inpatient psychiatric care, residential treatment centers, and crisis services. In addition, interviewees noted that the CTTs have done a better job than previous service models with coordination and education of schools, courts, and the police.

Another noted positive change is a focus on strengthening family relationships, and a growing respect for families within the Community Health Agencies. In addition, care managers are linking families with community resources, including Tennessee Voices for Children, a not-for-profit statewide advocacy agency for families whose children have emotional, behavioral, and/or mental health issues.

At the child and family level, CTT has enabled case managers to predict situations and problems before they escalate. Another perception is that CTT assists families because case managers have the time to offer them education and support: "Education and support equals openness to treatment." In addition, working in the home reinforces the belief that it takes more than a mental health professional to help a child with serious mental health problems. All family members, and their informal, natural supports, are valued and encouraged to participate in service planning. Interim evaluation findings also demonstrate positive youth and family outcomes.

Challenges and Problems

One challenge is recruitment and retention of case managers, especially in rural areas where the pay level isn't competitive with other opportunities. Retention of CTT case managers is higher than for regular case managers but remains a challenge. Another challenge related to staffing is that some case managers are hired without any previous experience in human services, and require additional training in the wraparound process, skills in offering in-home services, and crisis de-escalation techniques.

A second problem is that the program funding source is Medicaid only; this has eliminated flex funds, and the ability to pay for support services, such as respite or mentors. In rural areas, a challenge is that there are limited community resources, such as extracurricular activities, transportation, summer and after school programs, and recreation options. Another gap is the lack of independent living skill building programs for 16–18 year olds.

Another noted concern during the initial implementation phase was program fidelity. It was widely acknowledged that the level of fidelity to the CTT model varied among the Community Health Agencies. Based on a review of agency specific outcomes, evidenced based practices were established and the model was adjusted statewide to improve fidelity. Ongoing quality improvement processes will ensure adherence to program standards.

A final challenge is the need for more training on cultural competence for the CTT teams. For example, reportedly some case managers seem to lack an understanding of rural poverty. This issue has been raised by families who have been interviewed by Tennessee Voices for Children. One parent indicated that the case manager "would never come inside," and appeared quite uncomfortable with the family's environment.

Priority Change Areas

One noted goal is to have more flexibility with the intensity of services offered for each child and family. A further refinement would be to identify and target services to cohorts of youth with particular risk profiles.

An additional goal is that more “CTT-type services” would be offered as components of regular case management and outpatient services. Another recommendation is to implement a process for formal linkages between CTT case managers and family service coordinators from Tennessee Voices for Children. Finally, several interviewees noted the need to diversify the funding sources for CTT so that flex dollars and supportive services could be more widely available.

Fiscal Arrangements

Medicaid is the sole funding source for Continuous Treatment Teams. Each Community Health Agency receives a case rate per member to operate CTT.

• Care Coordination—Wraparound Milwaukee, WI

Background

Since 1984, **Wisconsin** has operated an integrated managed care system. Statewide, there are 13 Health Maintenance Organizations (HMOs) that offer health and mental health services. Wisconsin also has two special "system of care" carve outs for youth with serious emotional disorders—Children Come First in Dane County (Madison) and Wraparound Milwaukee. Wraparound Milwaukee is operated and administered by the Mental Health Division of the Milwaukee County Health and Human Services Department.

Wraparound Milwaukee is based on the wraparound approach and offers a comprehensive and flexible array of services to youth with serious behavioral health needs and their families. The enrolled population is exclusively youth with serious and complex disorders who have high levels of service needs. The system of care uses managed care technologies and approaches to oversee and manage service delivery. Initiated in 1995, its intent is to foster comprehensive home and community-based care and to reduce placements in psychiatric inpatient, residential care, and juvenile correctional facilities. As of spring 2005, Wraparound Milwaukee serves 630 youth and their families.

Key Components

Similar to the other care coordination promising approaches described earlier, Wraparound Milwaukee has a well-defined set of values and guiding principles (**Table 3**, page 25).

Care coordination is the foundation of Wraparound Milwaukee. Each enrolled youth and family is assigned to a care coordinator; the expectation is that this assignment will remain in place until the youth is discharged unless a family requests a change. The responsibilities of care coordinators include:

- Putting together the child and family team
- Performing a strengths-based assessment process
- Leading a team service planning process
- Conducting child and family team meetings
- Arranging for needed services and supports from an extensive provider network of community agencies offering an array of 80 different services, with family choice of providers, and entering services into a web-based Information System
- Monitoring the implementation of the service plan, including service delivery
- Coordination with child welfare and juvenile justice, including assisting with the preparation of court-related reports and appearances
- Ensuring that performance indicators (the Child and Adolescent Functional Assessment Scale (CAFAS) and the Child Behavior Checklist (CBCL)) are administered periodically and entered into the MIS system
- Coordination of the development of a crisis safety plan, with clear directions as to what should be done in crisis situations.

Table 3. Milwaukee Wraparound Value Base	
Build on Strengths to Meet Needs	Most existing programs have been designed around the child and family's deficits and problems. Wraparound Milwaukee's philosophy is centered around identifying a child and family's strengths because those personal, family, and community strengths become resources around which to develop an effective care plan.
One Family—One Plan	There should be a single care plan developed among all agencies serving that family. There should not be separate education plans, child welfare plans, mental health agency plans, etc. Care should be delivered in a seamless fashion.
Best Fit with Culture and Preferences	We must truly understand the culture and heritage of the families we work with to be competent to understand their needs.
Community-Based Responsiveness	Children are best served when cared for in the community rather than in institutions. Institutional placements are not natural settings and not where children want to be cared for.
Increase Parent Choice and Family Independence	The care plan and services delivered to families should be developed by the family and designed to help strengthen the family to make their own choices and ultimately to function independently. Families do not usually want to be dependent on formal system services any longer than necessary.
Care for Children in the Context of Families	Families usually are the best judges of what their children and families need. Family involvement is seen as integral to and not detrimental to the care planning process.
Never Give Up	Care should be provided in an unconditional manner. If a case plan is not working, change the plan—don't blame the family.

Wraparound Milwaukee has a strong quality assurance process for care coordination. The contracts with the community agencies that provide care coordination include a series of fiscal incentives and disincentives. Quality assurance staff at Wraparound Milwaukee conducts semi-annual performance reviews with the providers. Providers see how they rank with one another overall and on each of a set of performance indicators including:

- Proportion of successful discharges
- 15–16 hours of monthly contact with each child/family
- Days in restrictive settings versus days in community
- Unexcused school absences
- Average expenditures/family/month
- Level of family satisfaction
- Delinquent plans of care
- Percent of informal supports on child and family teams

Eligibility Criteria

Youth in Milwaukee County who would have been court ordered or placed in residential treatment settings are enrolled in Wraparound Milwaukee. There is no waiting list. When a youth is referred, an Assessment Team conducts a review. If the child meets the eligibility criteria, the child is accepted into care. The target population is defined as children and adolescents up to the age of 18 who have serious emotional, behavioral, or mental health needs and who are identified by the child welfare or juvenile justice system as being at immediate risk of placement in a psychiatric inpatient setting or a residential treatment center, and certain youth at immediate risk of entering a juvenile correctional facility who have a serious emotional, behavioral or mental health need. The youth's emotional problems have persisted for at least six months, with the expectation that they will persist for another six months or longer.

Involvement of Families/Youth in Team Meetings

Families are actively involved in the Child and Family Team meetings. The team includes all individuals who support the child and family, including family members, natural support identified by the family (such as relatives, neighbors, friends, church members), and individuals from other child-serving systems who are involved with the child. The goal is that 50% of the team members will be informal supports identified by the family. The semi-annual review of each care coordination provider includes this goal of 50% team membership by informal supports. The team may also link the family with Families United of Milwaukee, a family organization that operates support groups, sponsors family activities, and provides support to parents in crisis situations.

Staffing Requirements

Wraparound Milwaukee contracts with nine community agencies, each of which provides eight care coordinators, a lead care coordinator, and a supervisor. The educational requirement for a care coordinator is a bachelor's degree and hopefully some experience in children's services. Starting salary for a Care Coordinator is $26,000. All new Care Coordinators must go through a Certification process that includes five days of training in the wraparound process and all components of Wraparound Milwaukee. After one year, Care Coordinators must go through a Refresher Course. There also are monthly training sessions on special topics.

The expectation is that supervisors have a Master's degree. If not, they must have three years of care coordination experience. The starting salary is between $32,000 and $36,000, depending on previous experience. Supervisors who have not been care coordinators must go through the five-day Certification training process.

Caseload Size

The average caseload size is 1:9, with ten families as the maximum and eight as the minimum.

Reported Positive Impacts

Wraparound Milwaukee has had a ripple effect on the other child serving systems in the county. The child welfare system, for example, now uses a strengths-based approach and wraparound process for all the children and families in their system. There is stronger cross-system coordination, and a sharp reduction in the use of residential placements. By 2005, the system had reduced residential treatment placements from an average of 375 placements per day to 80 placements and juvenile correctional placements from over 300 to under 150 per day.

Challenges and Problems

One reported challenge is the recruitment of Care Coordinators, especially those with previous experience in children's services. The average length of employment for a Care Coordinator is two years.

Fiscal Arrangements

The Wraparound Milwaukee total system funding is approximately $32 million. It is financed through a pooled funding approach that blends the resources provided through the child welfare, juvenile justice, mental health, and Medicaid systems. The fund pool includes a monthly case rate of $3800 from the child welfare system for each enrolled child, an annual allocation of $8.5 million from the juvenile justice system intended to support 300 enrolled youth, a monthly capitation payment of $1557 for each child who is Medicaid eligible, and block grant funds from the mental health system. Of the youth served, 87% are Medicaid eligible. The care management organization (Wraparound Milwaukee) pools these funds to create maximum flexibility to meet the needs of youth with serious and complex needs and their families.

• Service Coordination—The Dawn Project, Marion County, IN

Background

Indiana has a statewide behavioral health managed care system, known as the Hoosier Assurance Plan that manages non-Medicaid behavioral health care services. The target population is children with serious emotional disorders and adults with serious and persistent mental illnesses. The Division of Mental Health contracts with 32 community mental health centers to offer mental health and substance abuse services as managed care entities. Each center receives a case rate for each individual with a serious mental health disorder or substance abuse problem who is served. The case rate is a supplement to financing from other sources, including Medicaid for Medicaid-eligible individuals.

In addition to the Hoosier Assurance Plan, Marion County has a managed care system for children and adolescents with serious emotional disorders and their families, known as the Dawn Project. The goal of Dawn is to enable youth with serious emotional disorders to remain in their homes and communities by providing a network of individualized, coordinated, community-based services and supports, using managed care technologies. Indiana Behavioral Health Choices, a care management organization that provides the necessary administrative, financial, clinical, and quality assurance to support service delivery, oversees the Dawn Project. Choices contracts with a provider network for care coordination and other services and supports, offers training and consultation, manages community resources, creates community collaboration and partnerships, and collects performance information on service utilization, outcomes, and costs.

Key Components

Each child enrolled in Dawn is assigned to a service coordination team, comprised of a supervisor, five or six service coordinators, and one resource support worker. Service coordination is guided by the system of care values and principles, and uses a wraparound approach. The service coordination approach (known as participatory care management) was developed by Dawn, and blends the concepts of managed care and systems of care. The approach integrates the core values of systems of care (e.g., individualized/wraparound process, cultural competence, care coordination) with managed care technologies for clinical and fiscal management (e.g., case rates, focus on outcomes). Service coordinators have a case rate ($4300/per child/per month) and are responsible for managing the expenditures. The service coordinator purchases all needed services and supports.

The tasks of the service coordinator include:

- Organize a child and family team
- Facilitate a strengths-based assessment process
- Develop with the team an individualized service coordination plan
- Up-to-date information about the resources of the provider network
- Authorize services on a monthly basis

- Monitor and evaluate service provision and outcome attainment
- Facilitate cross-agency, multi-system collaboration

Dawn has developed a set of guidelines for child and family teams; each team member receives a copy of a Dawn Project Team Handbook that lays out expectations and roles of team members, ground rules for team meetings, principles for conflict resolution, and a guiding set of service principles.

Table 4.

Service Principles for Child and Family Teams

1. Decisions are reached by general agreement, or consensus, whenever possible. Consensus is not always completely possible in cases involving legal restrictions.
   - All members have input into the plan
   - All members have ownership of the plan
2. Teams meet regularly, at least monthly, NOT just around crises.
3. Teams develop plans that are based on youth/family strengths.
4. Teams pay attention to and address a full range of life needs that may impact a youth/family.
   - Mental Health
   - Family
   - Living Arrangement
   - Medical
   - Legal
   - Vocational
   - Educational
   - Social/Recreation
   - Crisis/Safety
   - Cultural/Spiritual
   - Substance Use
5. Teams reach out for and utilize assistance from the family's natural support system, community-based programs, and professional providers.
6. Teams stay focused on realistic, attainable goals instead of on excuses why goals can't be reached.
7. Care is unconditional—change the plan, not the commitment, when success is not seen.

Eligibility Criteria

Dawn has two tiers of eligibility criteria. The first tier is children and adolescents who have "penetrated into" the public systems, such as child welfare, juvenile justice, and special education. These children have a DSM-IV diagnosis, have been in the public sector for at least four to five months, and have functional impairments in at least two areas. The second tier is children and adolescents who are just beginning to enter the public system. For example, they may be in special education but have no child welfare or juvenile justice involvement. They have a DSM-IV diagnosis, have a functional impairment in at least one area, and their CAFAS scores are lower than the Tier 1 youth. After some experimenting with a higher caseload for the 2nd Tier youth, Dawn has decided to use the same caseload size for both tiers of youth.

The eligibility criteria were developed by the systems that fund system, and the funders also make admission decisions. The average length of stay is 14–15 months, and typically there isn't a waiting list for service coordination.

Family Involvement

Dawn's policy is "no family/no team." The parents must be present at team meetings; no major decisions are made without the family's involvement. Youth participation in team meetings depends upon the child's age and maturity.

Staffing

A Service Coordination Team consists of a supervisor, five or six Service Coordinators, and a Resource Support Worker. The Service Coordination Team members are hired by the local community mental health centers, but they are "housed" at the Dawn Project. Service Coordinators must have either a Master's degree or a bachelor's degree in a human services related field (e.g., vocational rehabilitation, social work, recreational therapy, sociology, psychology, education) and three to four years of experience in children's services. If a person has a Master's degree but no previous experience, he/she is provided with a strong internship period.

Supervisors must have a Master's degree because the supervisors do the clinical sign-off and approval for Medicaid funded Psychiatric Rehabilitation services. The Resource Support Workers do "whatever it takes" to facilitate a family's completion of the treatment plan. Some typical tasks include transporting families to clinical appointments and meetings, attending team meetings, and acquiring knowledge about community resources and services. Several Resource Support Workers have been promoted to Service Coordinators.

The starting salary for a Service Coordinator is $32,000 to $38,000. Reportedly Dawn has no problem recruiting Service Coordinators, and doesn't need to advertise for openings. Supervisors' starting salary is $40,000 to $50,000.

Caseload Size

The caseload size is 8–9 children per service coordinator.

Discharge Criteria

From the time of the child's enrollment into Dawn, a goal is to define how the child and family will become self-sufficient and no longer need to be involved with the program. Continual reassessment of progress and outcomes occurs at the monthly team meetings. Decisions regarding discharge are made based on the completion of planned tasks and reaching desired outcomes.

Reported Positive Impacts

One of the positive impacts of Dawn's Service Coordination approach is that community mental health centers have learned that intensive case management models are effective and cost-efficient. They have adapted a 1:15 caseload size for adults with serious mental illness. Another benefit has been improved service coordination and collaboration among child welfare, children's mental health, juvenile justice, and special education.

Challenges and Problems

One of the challenges identified is closing the gap between using the language of wraparound and actually doing the wraparound process and service principles. Another challenge is to do the crosswalk between the strength-based practice of service coordination and the Medicaid procedure codes. This is especially challenging in states that do not have a Psychiatric Rehabilitation waiver. A final ongoing challenge is the tension between productivity standards for billing purposes and standards for good practice.

Fiscal Arrangements

Dawn is administered by Indiana Behavioral Health Choices, a nonprofit care management organization that was created by four Marion County community mental health centers as a separate independent entity to manage the Dawn system of care. Dawn is funded by a case rate provided by the participating child serving systems.

III. Discussion and Recommendations

A number of organizational and practice parameters are useful in describing and comparing case management interventions. Burns, Gwaltney, & Bishop (1995) articulated a set of organizational parameters for case management models: the case manager-to-client ratio, the frequency of contact between case manager and clients, and the duration of the service. Practice parameters of case management include the variables of focus of services, availability of service, the site where services are offered, and the amount and nature of client direction offered in the care coordination model (Willenbring, Ridgely, Stinchfield, & Rose, 1991). **Table 5** describes these parameters for each care management approach described in this volume.

Table 5.

Comparison of Case Management Parameters by Models

Care Management Model	Caseload Size	Number of Contacts	Duration	Focus	24/7	Site	Client Direction
Child and Family Teams	12-15		14-15 months	Child and Family	Yes	Community	Family directed
Coordinated Family Focused Care	10 Served by 2 people	Flexible	Flexible	Child and Family	Yes	Community	Family directed
Continuous Treatment Teams	6	12 contacts/ month	Flexible	Child and Family	Yes	Community and Office	Family and team directed
Wraparound Milwaukee	9	15–16 hours/ month	Flexible	Child and Family	Yes	Community	Family directed
Dawn	8-9	14 hours/ month	14-15 months	Child and Family	Yes	Community	Family directed

Caseload size and number of contact hours per month are proxies for the intensity of the care management model. As shown in **Table 5**, the caseload size ranges from a high of 15 children to a low of six, with most models serving between 8–10 children. At least two models (Continuous Treatment Teams and Wraparound Milwaukee) specify the amount of contact that is expected by the care manager with the family each month. Regarding the length of stay, most models do not specify an upper limit. Rather, the length of stay is flexible and based on the needs of the individual child and family. Fourteen to fifteen months is the average length of stay for Child and Family Teams in Maricopa County and the Dawn project.

All the models clearly state that the focus of care is the child within the context of the family, and that services are available 24 hours a day, seven days a week. Regarding the degree of client direction, four of the five models appear to be in the forefront of offering family driven care, defined as care where families have a decision-making in the role in the treatment of their children. Family driven has been described as: “This includes choosing supports, services,

and providers; setting goals; designing and implementing programs; monitoring outcomes; and determining effectiveness of all efforts to promote the mental health of children and youth" (US Department of Health and Human Services, 2005 p,16). Finally, all models are guided by the principle of community-based, with most services being offered in the home and community.

Policy and Practice Recommendations

Some interviewees across sites noted the need to begin with the development of a shared vision and set of principles, before the operational planning for care management. The visioning process can result in an agreed upon conceptual framework, such as a resilience model for children with serious emotional problems. The framework can then serve as the basis for the case management model. For example, the use of a strengths-based approach is very useful with families because it emphasizes what they are already doing well. Another suggestion was to emphasize the importance of communication and teamwork in the implementation of an intensive case management model.

Several recommendations relate to the organizational and program requirements that must be developed for a new care management program (Evans & Armstrong, 2002) is that the care management model needs to be well specified, with clearly defined job descriptions. A related decision is who will provide the care management. Wraparound Milwaukee and ValueOptions decided to contract out the care coordination process to a variety of community agencies. An advantage of this approach is the ability to include culturally diverse and indigenous community agencies. However, the providers must agree and be able to make arrangements so that care coordinators and family partners have flexible hours and working arrangements.

The planning process for implementation of a new care management model should be comprehensive, laying out a set of sequential steps that need to take place at all levels of the system, including the managed care entity, the state agencies responsible for behavioral health managed care, providers, and families and advocates. The implementation should be staggered so that unforeseen challenges can be addressed and resolved, rather than going to scale immediately. Start-up funds are essential, so that a full-scale training, coaching, and technical assistance plan can be carried out. The use of external resources for training and technical assistance can be useful. Finally, funds are needed for ongoing monitoring of the implementation of the care management approach.

Interviewees emphasized the need for a massive re-training effort, both of existing staff who will be re-assigned to the new care management approach, and of the system partners who serve these youth, including child welfare, juvenile justice, and education. In Arizona, child-serving system partners are regularly invited to attend Child and Family Team process training and coaching activities. The sequencing of training also is important; e.g. supervisors, clinicians, and out-of-home providers need to be targeted early in the training plan.

A related challenge is the need to educate the other child serving systems to the new care management process and driving principles. One site has shared crosswalks of the Child and Family Team process to congruent "best practice" approaches familiar to child welfare (e.g., family-group decision-making), developmental disabilities (personal futures planning), early childhood and juvenile justice partners; predicated on the incorporation of the same set of non-negotiables in those similar approaches, and with the assumption that behavioral health can simply "join" such existing processes instead of forming a new Child and Family Team where, in essence, one already exists.

Sequencing is also important in the recruitment, training, and hiring of direct service providers, such as respite caregivers and behavioral health aides, so that these resources are readily available as the needs are identified in service plans. The process of developing new service modalities is ongoing; in Milwaukee, for example, the provider network of community agencies currently offers families a choice of 80 different services.

Interviewees from several sites noted the challenge of recruitment and retention of care managers and family partners. One goal of Wraparound Milwaukee, for example, is to recruit Care Coordinators who are more mature and experienced in children's services. Their perception is that a new care coordinator's lack of experience can be an impediment in forming strong and trusting relationships with families.

Another challenge is to develop policies and procedures that monitor fidelity to the new care management process, and the related need for fiscal resources for training, coaching, and other quality assurance, quality improvement, and evaluation mechanisms. Some interviewees noted that the level of fidelity of the care management model varies across providers. Several sites emphasized the need for a standardized set of quality improvement supervision tools, and practice fidelity methods, including youth and family interviews with families and youth being served by the care management teams.

Some interviewees recommended that families who are being discharged could benefit from a transition step-down case management program so that the intensity of contacts could be gradually reduced.

For rural communities, telemedicine is a recommended vehicle for offering consultation and specialized assessments for children. AdvoCare has plans to offer this service to the Continuous Treatment Teams in the near future.

In the area of financing, one recommendation is for states to apply for a Psychiatric Rehabilitation waiver for Medicaid services. In comparison the Targeted Case Management, the waiver provides more flexibility in being able to offer creative service modalities, and to offer services in school and in communities.

Useful Resources

The care management programs identified both in-home resources that are available to other communities, and external resources that the sites found helpful.

• Child and Family Teams-Maricopa County, AZ

The following documents are available at www.hs.state.az.us

- Child and Family Teams Practice Improvement Protocol
- Child and Family Teams Technical Assistance Document
- Child and Family Team Process Encounters/Billing Codes Matrix

The Family Involvement Center has developed a checklist with the Eight Core Skills for Family Support Partners that can be used in the recruitment and selection process.

External resources identified by the sites typically were related to training, technical assistance, and consultation. Training consultants included Pat Miles, Vroon Vandenberg, and the TA Partnership resources offered to Child Mental Health Initiative sites by AIR. In the area of coaching, Paul Vincent's Policy and Practice Group was named.

For training of clinicians regarding the wraparound process and the use of Child and Family Teams, the site recommended the use of a "relational stance" in clinical treatment. The approach is taken from:

Madsen, William C. (1999). *Collaborative Therapy with Multi-Stressed Families: From Old Problems to New Futures*. New York: The Guilford Press.

• Coordinated Family Focused Care: MA

Materials available include a Program Description and Operations Manual, position descriptions, a quality management plan and resource materials.

- Child and Adolescent Continuous Treatment Teams: Tennessee
- Child and Adolescent Continuous Treatment Teams Clinical Guidelines

• Care Coordination—Wraparound Milwaukee, WI

Wraparound Milwaukee offers training and technical assistance to states and communities. Materials that are available include: the provider contract, training curriculum for the Certification process for Care Coordinators, quality assurance policies and procedures.

• Service Coordination—The Dawn Project, Marion County, IN

The Dawn project has job descriptions, best practice guidelines, productivity standards, a Service Coordinator Resource Manual, and a binder of Training Resources and Materials. Dawn also offers training and technical assistance to states and communities.

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Appendix A

Practice Improvement Protocol 9

The Child and Family Team

Developed by the Arizona Department of Health Services
Division of Behavioral Health Services

Effective August 13, 2003 Last Revised August 11, 2003

ADHS PRACTICE IMPROVEMENT PROTOCOL: THE CHILD AND FAMILY TEAM

ISSUE: The assurance that all TXIX and TXXI eligible members under the age of 21 receive behavioral health services in keeping with the 12 Arizona Principles.

PURPOSE: To establish protocols that effectively operationalize the Child and Family Team approach in Arizona.

TARGET POPULATION: All TXIX and TXXI eligible members under the age of 21 receiving behavioral health services through the T/RBHA system.

BACKGROUND: ADHS is committed to the provision of behavioral health services to children through family-centered practice. Such practice is based upon a coordinated, flexible, family-driven process that:

- Explores and documents the strengths and needs of a child and family;
- Establishes and prioritizes service goals;
- Identifies the supports necessary to meet those goals;
- Describes a course of action encompassed in a written plan developed by team members;
- Monitors accomplishments; and
- Determines the responsibilities of all team members in these efforts.

DEFINITIONS:

- **Child and Family Team:** The Child and Family Team is a group of people that includes, at a minimum, the child and his/her family, any foster parents, a behavioral health representative, and any individuals important in the child's life and who are identified and invited to participate by the child and family.[1] This may include, for example, teachers, extended family members, friends and other natural supports, family support partners, healthcare providers, coaches, community resource providers, representatives from churches, synagogues or mosques, agents from other service systems like Child Protective Services or the Division of Developmental Disabilities, etc. The size, scope and intensity of involvement of the team members are determined by the objectives established for the child, and by which individuals are needed to develop and coordinate an effective service plan, and can therefore expand and contract as necessary to be successful on behalf of the child.
- **Clinical Liaison:** As the concept applies to the Child and Family Team, a Clinical Liaison is a Behavioral Health Technician or Behavioral Health Professional who has met ADHS credentialing and privileging standards and whose responsibilities are to support the family in the development of the Child and Family Team, to provide clinical oversight and consultation to the Child and Family Team process and to advise the team on services, natural supports and providers whose involvement may benefit the team. Clinical liaisons are the individuals also responsible for performing the initial core assessment when additionally privileged to do so. A Clinical Liaison will be involved with every Child and Family Team.
- **Family:** The primary care-giving unit, inclusive of the wide diversity of primary care-giving units in our culture. Family therefore is a biological, adoptive or self-created unit of people residing together and consisting of adult(s) and children, with adult(s) performing duties of parenthood for the children. Persons within this unit share bonds, culture, practices and significant relationships. Biological parents, siblings and others with significant attachment to the individual living outside the home are included in the definition of family.

[1] In the case of children who may be legally dependent or delinquent, the custodial agency participates in the selection of team membership with the child and family.

PROCEDURES:

1. WHICH CHILDREN SHOULD HAVE CHILD AND FAMILY TEAMS?

While the original development of the Child and Family Team process has focused on children and families with the most complex needs, the intent of ADHS is to universally apply the Twelve Arizona Principles, and to use the Child and Family Team process with every child. The character of the team will vary based on the goals, needs and strengths of each child and family. As such, each team will be structured and will function in a unique and flexible manner that will require varying levels of involvement from the Behavioral Health system, other child-serving agencies, and other natural supports.

A further goal is to educate, support and empower families to eventually facilitate their own teams. Until the system has matured to this point, many situations (particularly

those serving multi-system involved families, children in out-of-home placements, children transitioning into the adult system, children whose placements are at risk, or children whose service plans have been unsuccessful) will likely require teams with greater complexity, and even designated facilitators. A designated facilitator should be provided to any team requesting one.

2. HOW DO CLINICAL LIAISONS AND OTHER BEHAVIORAL HEALTH REPRESENTATIVES SUPPORT THE WORK OF THE CHILD AND FAMILY TEAM?

When a child and family enter the behavioral health system, the individual completing the initial core assessment assumes the role of Clinical Liaison. During the initial assessment, the Clinical Liaison begins to work with the child and family to develop and support the Child and Family Team, and provides clinical oversight and consultation for the Child and Family Team as an active team member. The Clinical Liaison completes any remaining unfinished necessary assessment processes, modules or addenda. After the next steps for initial services have been decided at the initial core assessment, the Clinical Liaison continues to participate in a consultative role for as long as services are provided. If the identified needs of the child and family so require, the Clinical Liaison may transfer those responsibilities to a different Clinical Liaison who may be better fitted and available to work with them on a long-term basis. In cases where therapy is being provided, the Clinical Liaison will most likely be the therapist providing services to the child and family.

Each Child and Family Team shall have an assigned behavioral health representative as an active member. This representative may be a Behavioral Health Professional, a Behavioral Health Technician or a Para-Professional, and is responsible for assisting the Child and Family Team in treatment planning, securing behavioral health services, and any other processes requiring involvement or facilitation from the behavioral health system. In most cases, the behavioral health representative will be the Clinical Liaison for that Child and Family Team. With the assistance of the behavioral health representative, the Child and Family Team completes the Strengths and Culture Discovery and assumes responsibility for overseeing and facilitating decision-making regarding the child's behavioral health services and other identified areas of need.

Families have a powerful role in the Child and Family Team process, actively participating in the process of assessing needs, identifying team members, developing and implementing the plan. A key element of enlisting the family's participation is engaging the family with warmth, empathy, genuineness and respect.

The Child and Family Team is responsible for the supportive aspects of service provision and determines which of its members will oversee:

- Ongoing revisions as necessary to the assessment and treatment plan;
- Collaboration with other child-serving agencies or individuals identified as supports to the treatment process;
- Communication within the Child and Family Team;
- Ensuring the maintenance of continuity of care between behavioral health care providers and primary care providers and out-patient and in-patient behavioral health care providers; and

- Ensuring that appropriate covered services and supports are provided.

  If the behavioral health representative is not also the Clinical Liaison for the Child and Family Team, their respective responsibilities will be coordinated.

3. WHAT AUTHORITY DOES THE CHILD AND FAMILY TEAM HAVE IN SECURING SERVICES?

The Child and Family Team, with the assistance of the behavioral health representative, is responsible for overseeing and facilitating decision-making regarding the child's behavioral health services. Based upon the recommendations and decisions of the Child and Family Team, the behavioral health representative will formally secure any and all covered services (barring the exceptions listed below) that will address the needs of the child and family. The Child and Family Team is expected to carefully consider and give substantial weight to family preferences in formulating its views on the developing service plan, acknowledging the family's expert knowledge of their child.

In determining how to successfully meet its objectives, the Child and Family Team should not begin by identifying specific interventions, placements or services, but rather on the underlying needs of the child (and of the family in providing for the child) and on the type, intensity, and frequency of supports needed. As long as decisions are based on comprehensive reviews of the strengths and needs of the eligible child, are in accordance with the Twelve Principles of the Arizona Vision, and have objective and measurable outcomes, the RBHA should provide all covered services decided upon by the Child and Family Team with the following exceptions:

- Level I services which must be prior authorized in accordance with ADHS' policy on prior authorization.
- Covered services that the ADHS/DBHS Medical Director has approved for T/RBHA prior authorization processes in accordance with ADHS' policy on prior authorization.
- Service recommendations that the Clinical Liaison believes to be inconsistent with the Twelve Principles. In such a case, the Clinical Liaison attends all Child and Family Team meetings and actively participates in the service planning process until consensus is reached on a new plan that meets the needs of the child and the family.
- Services not covered by TXIX and TXXI funds.

4. WHAT ARE THE NON-NEGOTIABLES?

Other child-serving systems maintain processes that closely approximate the Child and Family Team process. Although they may use different terminology, (e.g. Person-Centered Planning Processes in developmental disabilities, or Family-Group Decision making processes in child-welfare), these processes can be embraced by the Behavioral Health System as legitimate Child and Family Team processes. What distinguishes a legitimate Child and Family Team process (by any name) is its inclusion of each of the following "non-negotiable" and distinct elements:

- **Strengths and Needs-Based Planning.** A Strengths and Culture Discovery is to be completed for each child and family. This discovery becomes part of the

foundation for treatment planning. All services should be customized to creatively reflect the child and family's unique culture and individual strengths in addressing the behavioral health needs of the child.

- **Partnerships with Families.** All plans resulting from the Child and Family Team process must incorporate identified strengths and address the identified behavioral health needs of the child and family. Professional members of the team must therefore be active partners with family members, ensuring that all agreed-upon plans reflect their values, priorities, strengths and needs. An initial goal of the process may therefore be to assist the family in discovering and articulating these factors.
- **Consensus.** All Child and Family Teams strive to reach consensus on the needs of the child and family, on the findings of the assessment process and on the service plan. No decision of the Child and Family Team is to be made without the approval of the parent or guardian, or, when appropriate, of the child or adolescent him/herself.
- **Jointly Established Behavioral Health Service Plans.** When children have multi-agency, multi-system involvement, a joint assessment is developed and a jointly established behavioral health service plan is collaboratively implemented.
- **Natural and Informal Supports.** Although Child and Family Team membership may vary with changing needs and developing strengths, teams are encouraged to strive towards memberships that are at least 50% natural and informal supports.
- **Collaboration.** Cooperation must be sought beyond the family itself and from other involved agencies, and from the community at large. The team should strive to promote positive connections with all the community has to offer rather than, for example, relying solely on paid supports. When children and families are involved with multiple child-serving systems at once, then collaboration demands the team's full respect for the societal mandates of each involved system (e.g. safety, for child welfare; learning, for education).
- **Ongoing Assessment.** The underlying needs and strengths of each family must be continually reassessed and addressed on an ongoing basis. While the initial assessment will always be completed within 45 days after the child and family enter the behavioral health system, the assessment process, including the Strengths and Culture Discovery, must be a continual, evolving course of action, and treatment planning an open-ended process. The Child and Family Team serves as the key point in making adjustments as may be needed to ensure successful goal attainment.
- **Child-Family Team Participation in All Decisions that Affect Them.** Providers must by necessity be able to interact, communicate and consult in the absence of a Child-Family Team. However, no meetings that result in decisions affecting the child and family should occur without the family's full participation. Decisions affecting substantive changes in service delivery should not be made without the participation of the full Child and Family Team.

- **Crisis Planning.** The Child and Family Team develops a crisis plan that predicts the most likely worst case scenario, includes strategies intended to prevent or mitigate that scenario, and a specific plan for what will happen if the crisis nevertheless occurs. Crisis planning seeks only to stabilize the crisis, not to change the overall plan; and incorporates family, friends and natural supports, as well as formal supports if necessary.
- **Flexibility that Avoids Redundant Processes.** Child and Family Teams must be flexible, and when necessary adapt their processes to accommodate parallel processes like DES Family Decision Making or permanency planning meetings, DDD Person-Centered Planning Meetings and Individualized Education Plan (IEP) meetings in special education.
- **Single Point of Contact.** One member of the Child and Family Team is assigned as the single point of contact, and assumes responsibility for coordinating information exchange among Child and Family Team members and providers regarding the provision of service.
- **Cultural Competency.** The Child and Family Team process, from the facilitation of Child and Family Team meetings to the provision of services, should be culturally competent and linguistically appropriate, building on the unique values, preferences and strengths of the child and family and of their community.

5. WHEN DOES THE CHILD AND FAMILY TEAM END?

The Child and Family Team process will be used with all children, regardless of the intensity of their needs. Although the character, frequency, and intensity of the process will vary over time and with changing family needs, the Child and Family Team does not "end" before the child is disenrolled from services or transitioned to the adult system (at which point, ideally, and according to need, the process will continue). Before any child is disenrolled, a crisis plan should be developed that outlines the specific steps that are to be taken to reconvene the Child and Family team, re-establish services and supports should it become necessary. Even at the point that behavioral health services are no longer necessary, or provided through the T/RBHA system, ADHS envisions the ongoing use of the skills, values and activities reflected in the Child and Family Team process.

Publications of the HCRTP

Publications of the Health Care Reform Tracking Project (HCRTP) are available on-line as viewable/printable Adobe Acrobat PDF files:

http://www.fmhi.usf.edu/cfs/stateandlocal/hctrking/hctrkprod.htm or

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

Reports of the Health Care Reform Tracking Project (HCRTP) are also available in print from the Research and Training Center for Children's Mental Health, at the Louis de la Parte Florida Mental Health Institute, University of South Florida, 13301 Bruce B. Downs Boulevard, Tampa, FL., (813) 974-6271:

HCRTP Promising Approaches Series

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HCRTP Impact Analyses

Pires, S.A., Stroul, B.A., & Armstrong, M.I. (2000). *Health care reform tracking project: Tracking state health care reforms as they affect children and adolescents with behavioral health disorders and their families — 1999 Impact Analysis.* Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute (FMHI), Research and Training Center for Children's Mental Health. (**New FMHI Publication #213-2**, formerly FMHI Publication #183)

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HCRTP Issue Briefs

The following Issue Briefs are available from the National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development, 3307 M Street, NW, Washington, DC 20007, (202) 687-5000:

Pires, S. A. (2002). *Issue Brief 4. Accountability for Children with Behavioral Health Disorders in Publicly Financed Managed Care Systems.* Washington, D.C.: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center.

Pires, S. A. (2002). *Issue Brief 3. Financing and Risk.* Washington, D.C.: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center.

Stroul, B. A. (2002). *Issue Brief 2. Special Provisions for Youth with Serious and Complex Behavioral Health Needs in Managed Care Systems.* Washington, D.C.: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center.

Stroul, B. A. (2002). *Issue Brief 1. Service Coverage and Capacity in Managed Care Systems.* Washington, D.C.: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center.

HCRTP Special Analyses: Child Welfare

The following special analyses related to the child welfare population are available from the National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development, 3307 M Street, NW, Washington, DC 20007, (202) 687-5000:

McCarthy, J. & Valentine, C. (2000). *Health care reform tracking project: Tracking state health care reforms as they affect children and adolescents with behavioral health disorders and their families—Child Welfare Impact Analysis—1999.* Washington, D.C.: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center.

Schulzinger, R., McCarthy, J., Meyers, J., de la Cruz Irvine, M., & Vincent, P. (1999). *Health care reform tracking project: Tracking state health care reforms as they affect children and adolescents with behavioral health disorders and their families—Special Analysis—Child Welfare Managed Care Reform Initiatives.* Washington, D.C.: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center.

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- Child and Adolescent Continuous Treatment Teams: TN
- Care Coordination Wraparound Milwaukee, WI
- Service Coordination: The Dawn Project, Marion County, IN
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- Key Components
- Eligibility Criteria
- Involvement of Families/Youth in Team Meetings
- Staffing Requirements
- Caseload Size
- Reported Positive Impacts
- Challenges and Problems
- Fiscal Arrangements
- Discussion
- Policy and Practice Recommendations
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Suggested Citation: Armstrong, M. I., (2005). Health care reform tracking project (HCRTP): *Promising approaches for behavioral health services to children and adolescents and their families in managed care systems—7: Care management in public sector managed care systems*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute (FMHI), Research and Training Centerfor Children's Mental Health. (**FMHI Publication #211-7**)

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By:

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