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.