B. The Dawn Project — Marion County, Indianapolis, IN

Overview

The Dawn Project is a behavioral health carve out serving a subset of children in Marion County (Indianapolis, Indiana). It focuses on Marion County children who have serious emotional or behavioral disorders, are involved in multiple systems, and are in or at risk for residential placement. Dawn serves about 150 children on any given day and has served over 600 youth and their families since its inception in May 1997. The average length of stay in care is 14 months. Several state and county agencies finance the project, including the State Mental Health Agency, the state special education agency, the county child welfare agency, and the juvenile court, creating a case-rate of $4,254 per member per month. Indiana Behavioral Health Choices (Choices), a nonprofit care management organization, acts as the managed care entity. The Dawn Project was created to integrate care for children involved in multiple systems and their families, including the child welfare, mental health, juvenile justice, and education systems, and draw on the strengths of families to reduce long-term system dependency and improve outcomes. Choices employs service coordinators, who are responsible for organizing and facilitating Child and Family Teams, which develop individualized service plans using a wraparound, strengths-based approach. The Dawn Project partners with families at all levels of the system and actively monitors quality and outcomes. It adheres to a values base that emphasizes the resiliency of children and families and their capacity for positive development when provided with family-centered, community-coordinated support.

Key Design and Financing Features

- **Nonprofit Lead Agency Care Management Organization.** Indiana Behavioral Health Choices, a nonprofit entity, acts as the lead agency for managing the care of children enrolled in the Dawn Project. It employs over 26 service coordinators and case managers, who coordinate Child and Family Teams. It utilizes an extensive network of providers in the community and has developed rates for a broad array of services and supports. Like Wraparound Milwaukee, Choices utilizes a variety of managed care technologies, including case-rate financing, service authorization mechanisms, quality improvement, utilization management, and care management. In addition to the Dawn project, Choices operates a youth emergency services component that provides immediate in-home crisis intervention and follow-up services for children and families who come to the attention of child protective services for reasons of abuse or neglect. It also operates a 24-hour crisis counseling and in-home support program for families struggling with children who have a history of running away or are at risk of running. Choices also operates a school truancy prevention component, a program serving families who are homeless or are at risk for homelessness, and a program serving adults who are homeless with a co-occurring disorder of mental illness and addictions. The Dawn Project draws on these in-house components of Choice, in addition to over 500 community providers.

- **Broad Benefit Design.** The Dawn Project covers a broad array of services and supports, which it has organized under nine major headings: (1) behavioral health services (e.g., individual and family therapy, day treatment, etc.); (2) psychiatric services (e.g., assessment, medication management); (3) mentor services (e.g., educational mentors, case aides, parent and family mentor, life coach/
independent living skills mentor, etc.; (4) placement services (e.g., residential treatment, therapeutic foster care, supported independent living, etc.); (5) respite services (e.g., crisis respite, planned respite); (6) supervision services (e.g., intensive supervision, community supervision); (7) discretionary (e.g., child care, clothing, groceries, etc.); (8) other services (e.g., camp, consultation with other professionals, team meetings, etc.); and (9) care management and service coordination. A diversified funding base and case-rate financing structure support the Dawn Project’s broad, flexible benefit design.

**Interagency Governance.** The Dawn Project utilizes a cross-system governing and oversight body for the Dawn Project, called the Dawn Project Consortium. It is comprised of the payor agencies, families, referring agencies, the managed care entity (i.e., Choices), advocates, and additional representatives from the public schools. The Consortium meets monthly. At the service-delivery level, Child and Family Teams work across agencies to integrate school plans, court orders, probation requirements, and mental health plans into one coordinated plan that is manageable for families.

**Partnership with Families.** One of the Dawn Project’s first initiatives was to establish a family support group, which over time has developed into a family support organization, Families Reaching for Rainbows, the Marion County chapter of the national Federation of Families for Children’s Mental Health. The organization provides support and advocacy for families enrolled in Dawn and also provides general advocacy, information, and education for families in Marion County. Family members participate as partners on Child and Family Teams and, as noted above, also serve on the governance body for the Dawn Project.

**Service Coordination and Clinical Management.** Children are referred to the Dawn Project from the child welfare, juvenile probation, or special education systems based on established eligibility criteria (i.e., child has a serious emotional disorder and is in or at risk for residential treatment or hospitalization). A child’s enrollment in Dawn activates assignment to a **Service Coordinator** who organizes and facilitates a **Child and Family Team.** This team, comprised of the child, family members, other natural supports, and relevant providers and agencies, develops a services plan that draws on the child’s and the family’s strengths and integrates action steps across life domains (e.g., school, home, etc.). Every service plan also contains a clearly defined crisis plan that includes 24-hour response and clearly-defined roles for team members, including family members and youth. The Dawn Project has the philosophy that “families don’t fail, plans do”, so it aggressively manages service plans by having teams meet monthly. Service Coordinators carry very small caseloads (1:8). They are able to authorize funds for agreed upon services. They are supported by Indiana Behavioral Health Choices clinical management software, called **The Clinical Manager (TCM)**, which has integrated clinical and fiscal data capabilities. TCM maintains the following information: consumer demographics; comprehensive intake assessment information; family/team member data; contact management; medication management; education/health/placement histories; treatment planning information, including needs and problems, goals and outcomes, interventions and strategies, authorizations, and strengths and supports; cost approval and analysis data; and claims adjudication.
• **Extensive Provider Network.** The Dawn Project utilizes over 500 vendors, and has established rates for an extensive array of services. Residential, group, and foster care programs that it uses are licensed by the child welfare agency in Marion County. The provider network encompasses both clinical treatment services and informal support services.

• **Training.** Training is a key component of the Dawn Project. Service Coordinators receive initial and ongoing training. Dawn uses a training format in which service coordinators, supervisors, and managers receive 90 minutes per week of training covering a variety of topics to support and enhance performance. In addition, supervisors participate in meetings/trainings with Choice management every two weeks. Family members are involved both as recipients of trainings and as trainers. Trainings are also available to providers in the network.

• **Case-Rate Financing and Flexible Funds.** As noted earlier, the Dawn Project is financed by several state and county agencies, whose dollars support a case-rate of $4,254 per member per month (the project started with a case-rate of $4,130; it increased by 2% after three years of implementation). Figures 5 and 6 show how Dawn is funded and its cost allocation breakdown.

The case-rate structure and Dawn’s internal financial management structure allow for flexible funding of services and supports, with service coordinators having access to **flexible dollars** in a quick turnaround mode.
• **Outcomes Monitoring.** The Dawn Project Consortium created an Outcomes Committee to develop a set of performance indicators for the Dawn Project. Current outcome measures include the following:

1. improved child and family functioning, including improved school functioning, improved records with the child welfare and juvenile justice systems, improved records for community supervision for Department of Corrections youth, improved CAFAS scores, progress on service coordination plans, and fewer days in out of home placement;
2. increased family autonomy, measured by a decrease in the number of paid providers and a Caregiver Strain Questionnaire;
3. parents/families feel more effective, as measured by a Family Assessment Device;
4. commitment of caregivers to the plan of care, measured by team meeting attendance;
5. services meet the real needs of the child and family, measured by narrative reports based on service coordinator focus groups;
6. decreased cost per child; and
7. child and family receive cost-effective services.

In addition to monitoring outcomes for clinical and financial accountability to guide project management and service coordinators, an interdisciplinary team of researchers, partnering with family members, providers, and administrators is implementing a comprehensive evaluation plan. The Evaluation Study focuses on six general areas: (1) profile of Dawn project participants; patterns and costs of service use; (2) dynamics of service coordination teams; effectiveness; family involvement; and (3) system level functioning. Cost data to date indicate that the Dawn project, at a cost of $4,130 per child per month is less costly to Marion County than standard treatment at a cost of $6,017 per child, and that clinical functioning of children enrolled in Dawn improves between enrollment and six months. The cost differential appears to be related to reduced reliance on residential treatment in the Dawn Project. In addition, the management mechanisms in place at the Dawn Project have reduced significantly double and duplicate billings for services rendered.

• **Management Information System.** The Dawn Project is supported by a customized management information system that provides real time clinical and cost information. The system supports Service Coordinators in making quick plan adjustments as needed and in readily accessing flexible funds. It also supports the outcomes monitoring process and Evaluation Study.
C. Massachusetts — Mental Health Services Program for Youth (MA-MHSPY) Cambridge, MA

Overview

The Massachusetts-Mental Health Services Program for Youth (MA-MHSPY) in Cambridge, Massachusetts, is an integrated physical-behavioral health managed care initiative serving a subset of children and their families. It focuses on Medicaid-eligible children in the Cambridge and Somerville communities and has recently expanded to the communities of Malden, Everett, and Medford, MA. It focuses on children and adolescents who have persistent symptoms of serious emotional disturbance, risk of out-of-home placement, significantly impaired functioning, and multi-agency involvement. The purchasers are several State agencies, including Medicaid, Child Welfare, Mental Health, Juvenile Justice, and Education. These child-serving agencies have agreed to “blend” their dollars, which combine to create a case-rate of $3,283 per member per month. The managed care entity is Neighborhood Health Plan, a nonprofit health maintenance organization, which manages the system and provides directly or contracts for medical, behavioral health, and social support services. With the recent expansion to Everett, Malden, and Medford, the system has the capacity to serve 100 children at any given time, and the average length of stay is 16 months. It is unique in its integration of primary care with behavioral health in a “system of care” approach. The MA-MHSPY philosophy stresses individualized, comprehensive, culturally appropriate, strengths-based, and coordinated services designed and implemented in partnership with families. It stresses the importance of continuity in settings and relationships and the quality of the relationship between the clinician and child and family.

Key Design and Financing Features

- **Health Plan as Home Base.** MA-MHSPY is, in effect, a small, customized service delivery and care management program housed within a large health insurance plan, Neighborhood Health Plan, which serves as the managed care entity for MA-MHSPY. This is a rather unique arrangement in that, historically, MHSPY-like initiatives have not utilized health plans as care management entities, but instead, like the Dawn Project and Wraparound Milwaukee, which have many similarities to this project, have used government, quasi-government, or community-based nonprofits in care management roles. Unlike traditional HMOs or MCOs, however, Neighborhood Health Plan (NHP) specializes in coverage for Medicaid populations, particularly special needs populations, such as persons with HIV/AIDS and adults with disabilities. Many of its staff come from public systems or community health centers. An advantage to using

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13) Note. Readers are cautioned against making direct comparisons between case-rates in different initiatives. There are many reasons for differences, (e.g., benefit structures and service costs). Benefit designs typically differ. For example, MHSPY’s case-rate of $3,283 encompasses both physical and behavioral health care, but it has a 30-day stop-loss on respite and residential services. The Dawn Project's case-rate of $4,130 does not include physical health care, but it must support as much residential and respite care as a child and family uses.

14) In the early to mid 1990s, the Robert Wood Johnson Foundation (RWJ) launched the Mental Health Services Program for Youth (MHSPY), which funded eight states and cities initially to implement MHSPY projects; Wraparound Milwaukee was one of these projects. RWJ then funded 12 more “replication” sites, of which the MA-MHSPY and DAWN projects are two.
a health plan as the management entity is that it allows MA-MHSPY to have increased contracting power compared to its small membership base and facilitates access to an established primary care network. However, MA-MHSPY still has had to develop specialty services and supports not found in NHP’s customary network, and there remains a certain “culture clash” and tension between the health plan structure and approach that supports provision of usual and customary care and MA-MHSPY’s highly individualized approach and need for flexibility in system structures. The health plan’s policies and procedures, (e.g., claims processing) all have required some customization to accommodate MA-MHSPY, a reality that creates challenges for both NHP and MA-MHSPY.

- **Broad Benefit Design.** The MA-MHSPY project covers a very broad array of services and supports, including: primary and specialty medical care through the enrollment of children in Neighborhood Health Plan; traditional and nontraditional mental health and substance abuse services; wraparound family, educational, and community supports; mentoring, care coordination, and care management. Children enrolled in MA-MHSPY are eligible to receive MassHealth (i.e., Medicaid) standard services plus enhanced mental health and substance abuse and social support services for the child and family, delivered in the home, school, or community. Services and supports include: short-term residential treatment; therapeutic after-school day treatment; respite; crisis intervention services; family support services, such as parent training, behavior management training, parent aides, parent support, and in-home respite care; education, training, and clinical consultation; recreation services; day and overnight camping; individual programming in developmental skill areas; case aides; mentors; transportation; care coordination; direct clinical services; case consultations; family consultations; case administration; flexible funds; and nontraditional supports. The broad array of services is supported by “blended” funding from multiple state agencies.

- **Interagency Governance and Coordination.** MA-MHSPY is governed by an interagency steering committee that sets policy. The MA-MHSPY Steering Committee is comprised of senior staff from the central and regional offices of the state Departments of Education (DOE), Mental Health (DMH), Social Services (DSS), Youth Services (DYS), and Medical Assistance (DMA), parents of children with serious emotional disorders, and senior managers from NHP/MA-MHSPY. In addition, MA-MHSPY is supported operationally by an Area Level Operations Team (ALOT Team). The ALOT Team reviews enrollments, serves as an interagency management and problem-solving resource for MA-MHSPY’s Care Planning Teams (discussed below), and facilitates collaboration. It is comprised of: DMH Children’s Case Management Supervisor; DSS Area Program Manager; DYS Day Reporting Center Director; DMA MA-MHSPY Project Manager; special education designees from each local school department; MA-MHSPY Enrollment Coordinator; NHP/MA-MHSPY Medical Director and Clinical Supervisor. MA-MHSPY’s Care Planning Teams develop individualized plans of services and supports that are integrated across these systems.

15 While another potential advantage to using a health plan is the ability to spread the higher costs of a special population like MA-MHPY’s across a much larger membership base, that is not what occurs in this situation. Costs for MA-MHSPY are borne almost solely by the MA-MHSPY budget.
• **Care Planning and Clinical Supervision.** MA-MHSPY/NHP directly employs Care Managers, who are masters-level, licensed mental health clinicians with experience and training in family therapy and team facilitation. They provide care coordination, leading the care planning process, and direct clinical services, working directly with family members, and case administration, authorizing services and documenting care planning processes and outcomes. Care Managers carry small caseloads of 1:8. Every child and his/her family that is enrolled in MA-MHSPY is assigned a Care Manager, who organizes and facilitates a Care Planning Team (CPT). These teams are family-focused and engage in a structured process to identify strengths and concerns and establish goals and timeframes to create an Individualized Care Plan. CPTs include parents, including parent advocates (see below), all relevant providers and agency/school staff, and significant support people in the family’s life, in addition to MA-MHSPY’s Care Manager. It is a goal of MA-MHSPY that the family and nonprofessionals invited by the parents make up 50% of the MA-MHSPY CPT, reinforcing a value that the family is at the center of the care planning process. All Individualized Care Plans include detailed crisis plans. Care Managers have the authority to authorize services agreed upon by the CPT and monitor implementation of the plan. CPTs meet at least monthly to review implementation of care plans and evaluate progress toward treatment goals. Senior licensed mental health clinicians supervise Care Managers, providing weekly individual supervision, and a child psychiatrist leads the overall MA-MHSPY program and provides weekly group supervision. In addition, MA-MHSPY stresses ongoing training opportunities for Care Managers, as well as for parent partners (see below).

• **Parent Partners.** MA-MHSPY employs two full-time equivalent Parent Coordinators and part-time parent partners, who support parents of children enrolled in MA-MHSPY at Care Planning meetings, school meetings, court appearances, etc. In addition, MA-MHSPY is allied with the statewide family advocacy organization, Parent-Professional Advocacy League (PAL), which organizes recreational and education and support activities for parents in general. MA-MHSPY’s Clinical Manager sits on PAL’s Board, and the two organizations collaborated on developing a training curriculum on family collaboration. As noted, there also is parent representation on the MA-MHSPY Steering Committee, the governance body for the project. MA-MHSPY stresses a family-focused approach, having families at the center in the care planning process and building on family strengths to improve outcomes and reduce system dependency.

• **Enrollment Process and Integration with Primary Care.** MA-MHSPY enrollment is handled by the state Medicaid agency, which receives referrals from the child welfare, juvenile justice, mental health, and education systems. When families enroll their children with MA-MHSPY, they, in effect, are enrolling in Neighborhood Health Plan, and their primary care providers either must have an existing relationship with NHP or be added to the network. MA-MHSPY has had the advantage of an existing primary care relationship by virtue of its being housed in NHP; in addition, the pediatric group used by NHP had a history of working in the community. However, MA-MHSPY has also had to develop relationships with primary care providers outside of NHP’s network. MA-MHSPY stresses that integration with primary care requires either an
established relationship with primary care providers or the means (time and appropriate staff) to develop those relationships, and the program must be able to offer payment to primary care providers, if necessary, to participate in meetings. Ironically, MA-MHSPY has yet to have to spend dollars to enlist the cooperation of primary care providers in service planning. However, the program believes that its ability to pay providers for their time spent in meetings is essential, that it creates a positive climate for collaboration.

- **Case-Rate Financing Structure.** As noted earlier and as illustrated by Figure 7, several State agencies “blend” dollars to finance a $3,283 case-rate for the MA-MHSPY project.

<table>
<thead>
<tr>
<th>Agency</th>
<th>Share</th>
</tr>
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<tbody>
<tr>
<td>DMA</td>
<td>$541</td>
</tr>
<tr>
<td>DMH</td>
<td>$842</td>
</tr>
<tr>
<td>DYS</td>
<td>$216</td>
</tr>
<tr>
<td>DOE</td>
<td>$842</td>
</tr>
<tr>
<td>DSS</td>
<td>$842</td>
</tr>
</tbody>
</table>

*Figure 7 MA–MHSPY Case-rate Breakdown*
Figure 8 shows the distribution by cost of clinical services supported by the case-rate.

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Cost Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tracking/Mentor</td>
<td>17%</td>
</tr>
<tr>
<td>Case Aide/Outreach</td>
<td>17%</td>
</tr>
<tr>
<td>Recreation</td>
<td>7%</td>
</tr>
<tr>
<td>Recreation</td>
<td>4%</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>2%</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>5%</td>
</tr>
<tr>
<td>Medical</td>
<td>5%</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>2%</td>
</tr>
<tr>
<td>Medical</td>
<td>5%</td>
</tr>
<tr>
<td>Flexible Fund</td>
<td>13%</td>
</tr>
<tr>
<td>Hospital</td>
<td>9%</td>
</tr>
<tr>
<td>Family Support</td>
<td>14%</td>
</tr>
<tr>
<td>Family Therapy</td>
<td>5%</td>
</tr>
<tr>
<td>Day Treatment</td>
<td>5%</td>
</tr>
<tr>
<td>After School</td>
<td>5%</td>
</tr>
<tr>
<td>Acute Residential</td>
<td>5%</td>
</tr>
<tr>
<td>Transportation</td>
<td>5%</td>
</tr>
</tbody>
</table>

**Family Support** — includes crisis intervention, family support, family advocacy, and parent support, family stabilization, team and parent education.

**Therapy** — includes individual and group therapy.

**Tracking/Mentor/Case Aide/Outreach** — is composed of tracking, mentor, case aide, and outreach counseling service.

**Recreation** — includes both day and overnight services, activities therapy, and family night.

MA-MHSPY costs have run at about 92% of the case-rate on average over the past three years and, reportedly, significantly less than the cost that “usual and customary” care would have run. Particularly as compared to the costs of residential treatment, MA-MHSPY is demonstrating significant cost savings.
• **Outcomes Accountability.** MA-MHSPY tracks clinical and functional outcomes, using a variety of measures, including the Child and Adolescent Functional Assessment Scale (CAFAS) and the Child Global Assessment Scores (CGAS). It also tracks the cost of care and family satisfaction. Their family satisfaction rating is 93%, and their program retention rate is 98%. Their data also indicate that, across school, home, and community domains, there has been a 38% improvement in level of functioning, on average, at 6 months after enrollment in the program and a 43% improvement at 16 months. As noted above, data also show cost efficiencies, particularly in comparison to the cost of residential treatment.

Figure 9 provides a graphic overview of the MA-MHSPY project:
D. Utah Frontiers Project

Overview

The Utah Frontiers Project is an interagency initiative that includes support from the Utah Medicaid Prepaid Mental Health Plan, a behavioral health carve out serving Medicaid-eligible children. The Utah Frontiers Project (Frontiers) serves six counties in areas of the State that are so remote and sparsely populated that they are characterized as frontier communities. Frontier counties have a population density of less than seven persons per square mile. As an interagency initiative that draws on resources from across existing child-serving systems, Frontiers is able to serve not only Medicaid-eligible children but also non Medicaid-eligible children. The target population includes children with serious emotional disorders, ages birth to 17 (or up to age 21 if receiving special education services), who live in the designated frontier communities. Frontiers serves about 200 children and their families at any given time. Frontiers utilizes an interagency governance and management structure based on the Families, Agencies, and Communities Together (FACT) structure that was mandated by State legislation in 1993. The FACT legislation, which was based on system of care values and principles, required interagency, community, and family collaboration to improve outcomes for children and families. Clinical management for Frontiers is provided by interagency service planning and monitoring teams, called WRAP Teams. The Utah Prepaid Mental Health Plan pays for many of the services needed by Medicaid-eligible children involved in Frontiers. FACT legislative requirements were built into Prepaid Mental Health Plan contracts.

Family partnership and extensive use of natural and community supports are critical to the Frontiers Project as these communities are characterized by severe shortages of clinical services, vast distances that separate people, limited dollars, and misconceptions about mental health services. Frontier values that stress self-reliance, conservatism, distrust of outsiders, religion, work-orientation, and individualism make it essential that families and trusted community figures are partners in care planning and delivery. Thus, engaging families and drawing on community supports is a major element of the Frontiers Project. The specific goals of the project are to: develop comprehensive and quality wraparound services, utilizing natural supports and community/family members as service providers; develop effective and accountable clinical and governance structures to monitor and manage the process for service planning and delivery; provide culturally competent and clinically sound services to the target population by fully involving children and families in project planning, development, implementation, management, and evaluation; and maximize existing fiscal and human resources to enhance and sustain services.

Key Design and Financing Features

- **Interagency Governance and Management Structure.** Frontiers utilizes an interagency governance and management structure that grew out of the FACT legislation. Each county has a Local Interagency Council, comprised of family and community members and agency representatives. The Local Interagency Council meets at least monthly to determine which children will be referred to Frontiers and to oversee service planning (i.e., WRAP) teams. At a minimum, the Local Interagency Councils conduct reviews of children in care every 90 days. The Local Councils also have flexible funds available to purchase nontraditional supports for children and families. The Community Mental Health Centers (CMHCs) in each county play an
additional management role (in addition to participating on the Local Interagency Councils). CMHCs are the managed care entities for the Utah Prepaid Mental Health Plan, which covers many of the services and supports provided to Medicaid-eligible children involved with Frontiers. CMHCs in the Frontiers counties have created administrative teams, which meet monthly to review utilization and administrative issues that arise in connection with Frontiers. CMHC administrative teams help to inform the work of the Local Interagency Councils.

- **Benefit Design.** Frontiers covers a broad array of services and supports, virtually anything that a WRAP Team identifies, because the project draws on the existing resources of all child-serving systems and resources within the community and family as well. The Utah Prepaid Mental Health Plan can cover many nontraditional services and supports for Medicaid-eligible children involved in Frontiers, in addition to more traditional clinical services, through a "Creative Interventions" service category that was built into the benefit design specifically with the needs of rural and frontier communities in mind. The Creative Interventions category can cover such services and supports as respite, home- and school-based services and supports, collaborative consultation, telephone consultation, and culturally responsive services, such as traditional Native healers. Prior to the introduction of managed care, which allows for flexibility in the types of services and types of providers covered, it would have been very difficult, if not impossible, for the Medicaid fee-for-service system to support a Frontiers-type of project, with its highly individualized approach that relies heavily on use of natural helpers and nontraditional services and supports.

- **Individualized Service Planning and Delivery.** The FACT legislation mandated that child-serving systems collaborate to provide needed services and supports through a single coordinated Individualized Service Plan (ISP). The legislation emphasized that the ISP must be culturally competent, family-focused, and community-based. Under the auspices of the Local Interagency Councils in each Frontiers county, individualized service planning teams, called WRAP Teams, identify strengths, resources, and needs of children and their families and develop plans of care in a wraparound approach. WRAP Teams are comprised of families and youth, other natural helpers and community supports, and relevant providers and agencies. Because of the scarcity of traditional services as well as the culture in frontier communities, WRAP Teams rely heavily on natural helpers, such as family members, and nontraditional supports in a child's community as a basic element of care. Plans of care also include defined crisis plans, which again involve natural helpers in specific ways because the long distances in frontier communities to formal crisis intervention systems preclude overreliance on those systems. Plans of care typically also designate a case manager. Frontiers does not directly hire or contract for case managers; instead, it draws on existing resources from all of the child-serving agencies, including schools, and family members as well, to be case managers. As noted earlier, Frontiers utilizes a case review system, in which the Local Interagency Councils review cases every 90 days at a minimum. In addition, the CMHC administrative team reviews service utilization of children in care who are eligible for the Utah Prepaid Mental Health Plan.
• **Parent Partnership.** The Utah Federation of Families is a partner in the development, implementation, and evaluation of Frontiers. Family representatives participate in the key governance and management structures for the project, as noted earlier, and are very much part of the WRAP Team process. Parents are paid by the State to provide technical assistance and on-site monitoring to Frontiers (and other) counties. Frontiers also uses paid family facilitators, whose role it is to reach out to and support families of children with serious emotional disorders in the Frontiers communities. These facilitators work closely with the WRAP teams. Family members play a critical role in outreach to families who may be reluctant to seek services because of stigma about mental health services or a distrust of government systems. The Frontiers communities are home to diverse cultures, including American Indian and Latino families, and to political and religious subcultures, such as polygamists, who have distinct cultural beliefs and practices. The Frontiers Project relies heavily on family members to reach out to diverse populations and help to dispel myths and misconceptions related to mental health services.

• **Financing.** Managed care has enabled the State to broaden the array of services and supports paid for by Medicaid and incorporate greater flexibility in service provision. In addition, the FACT legislation provided Local Interagency Teams with flexible dollars. Frontiers also has used federal Center for Mental Health Services grant dollars creatively to finance, among other elements, significant training (see **Training and Technical Assistance**, page 44). For the most part, however, Frontiers is based on a financing strategy of maximizing *existing* resources — from across all child-serving systems and within the community — and of creating a culture in which the question of efficacy is continually asked to avoid ineffective use of scarce dollars.

• **Training and Technical Assistance.** Frontiers views training as a fundamental strategy for achieving sustainability. It embraces a unified training approach across child-serving systems and with families and has focused on training related to evidence-based practices, such as Functional Family Therapy. In addition, Frontiers draws heavily on training related to utilizing and supervising a wraparound services approach.

• **Evaluation.** The State emphasizes the importance of evaluation and partners with families in monitoring and evaluating activities. Families, for example, are involved in monitoring Prepaid Mental Health Plan contracts as members of the state Department of Mental Health’s Child Team, which visits MCOs annually; these visits also are used as opportunities to identify areas for technical assistance. Families also have been involved in developing instruments to measure families’ perceptions of care and burden of care. Frontiers builds on these efforts to create a participatory evaluation process that measures:

1. outcomes at the child/family level, measuring change in presenting symptomatology, functional status at home, school and community, stability of living arrangements, and family function;
2. outcomes at the systems level, measuring such elements as service capacity and competence of staff as a result of training; and
3. process measures that evaluate satisfaction, experience of care, perception of collaboration, and the integrity of the wraparound process.