Building Systems of Care
New Mexico Primer Training

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OBJECTIVES OF PRIMER TRAINING

• To build common understanding of system of care concept

• To strengthen the knowledge base and skills of system of care leaders to operate strategically in system building

• To give system of care leaders teaching tools to use in their respective communities

Definition of a System of Care

A system of care incorporates a broad, flexible array of services and supports for a defined population that is organized into a coordinated network, integrates care planning and management across multiple levels, is culturally and linguistically competent, builds meaningful partnerships with families and youth at service delivery, management, and policy levels, and has supportive policy and management infrastructure.

National System of Care Activity

- CASSP - Child and Adolescent Service System Program
- RWJ MHSPY – Robert Wood Johnson Mental Health Services Program for Youth
- CASEY MHI – Annie E. Casey Foundation Urban Mental Health Initiative
- STATEWIDE FAMILY NETWORK GRANTS
- YOUTH MOVE - Center for Mental Health Services grants
- CMHS GRANTS – Center for Mental Health Services grants
- CSAT GRANTS – Center for Substance Abuse Treatment
- ACF GRANTS – Administration for Children and Families
- CMS GRANTS – Center on Medicare and Medicaid Services
- PRESIDENT’S NEW FREEDOM MENTAL HEALTH COMMISSION
- STATE CHILD AND ADOLESCENT INFRASTRUCTURE GRANTS
System of care is, first and foremost, a set of values and principles that provides an organizing framework for systems reform on behalf of children, youth and families.

Values and Principles for a System of Care

CORE VALUES

- Child/youth centered and family focused
- Community based
- Culturally and linguistically competent

Values and Principles for a System of Care

• Comprehensive array of coordinated services and supports
• Individualized services guided by an individualized service and support plan
• Least restrictive environment that is clinically appropriate
• Families, surrogate families and youth full partners in all aspects of the planning and delivery of services
• Integrated services and linkage to natural helping networks
• Care management or similar mechanisms
• Early identification and intervention
• Smooth transitions to adult services
• Rights protected, and effective advocacy efforts promoted
• Receive services without regard to race, religion, national origin, gender, sexual orientation, physical disability or other characteristics
• Services received are sensitive and responsive to cultural differences and special needs

Cross-Cutting Characteristics

• *Cultural and linguistic competence*, that is, processes and structures that support capacity to function effectively in cross-cultural situations;

• *Meaningful partnership with families*, including family-run organizations in system building processes and structural decision making, design, and implementation;

• *Meaningful partnership with youth*, including youth-run or youth guided organizations;

• *A cross-agency perspective*, that is, processes and structures that operate in a non-categorical fashion;

• *State, local and Tribal partnership* and shared commitment.

Behavioral Health is Consumer and Family Driven

*Family-driven means* families have a primary decision-making role in the care of their own children as well as the policies and procedures governing care for all children in their community, state, tribe, territory and nation. This includes:

- choosing supports and services
- setting goals
- designing and implementing programs
- partnering in funding decisions
- monitoring outcomes and determining the effectiveness of all efforts to promote the mental health and well being of children and youth.
Definition of Youth Guided

“Young people have the right to be empowered, educated, and given a decision-making role in the care of their own lives as well as the policies and procedures governing the care of all youth in the community, state, and nation.”

www.tapartnership.org/youth/youthguide/asp
### How Systems of Care Are Structuring Family and Youth Involvement at Various Levels of the System

<table>
<thead>
<tr>
<th>Level</th>
<th>Structure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy</td>
<td>At least 51% vote on governing bodies; as members of teams to write/review RFPs and contracts; as members of system design workgroups and advisory boards; raising public awareness; state and local committees</td>
</tr>
<tr>
<td>Management</td>
<td>As administrators; part of quality improvement processes; as evaluators of system performance; as trainers; as advisors in selecting personnel; full time youth coordinator</td>
</tr>
<tr>
<td>Services</td>
<td>As members of team for own children/youth; service delivery providers, such as family support workers, care managers, peer mentors, youth group development, system navigators</td>
</tr>
</tbody>
</table>

Cultural and Linguistic Competence

Goal 3: Disparities in Mental Health Services are Eliminated
- Racial & ethnic minority populations are underserved
- Racial and ethnic minorities face barriers to receiving appropriate mental health care
- Cultural issues also affect service providers
- Rural America needs improved access to mental health services

The Influence of Culture & Society on Mental Health
Mental Health Care for African Americans
Mental Health Care for American Indians & Alaska Natives
Mental Health Care for Asian American & Pacific Islanders
Mental Health Care for Hispanic Americans
Vision for the Future

Cultural & Linguistic Knowledge and Skills: Realities

- Demographic changes in the United States
- Issues of disproportionality.
  - Over-representation in restrictive levels of care, child welfare systems and in out-of-home placements. E.g. African Americans represent only 15% of the total population but their children comprise 40% of the foster care population
- Issues of disparities
  - racial and ethnic minorities have less access to and availability of services
  - racial and ethnic minorities are less likely to receive appropriate services
  - racial and ethnic minorities often receive a poorer quality of services and supports and less likely to achieve permanency outcomes
  - racial and ethnic minorities are underrepresented in research (e.g., Evidence Based Practice)
- Legislative and regulatory mandates.
- Class action lawsuits.

Why Culture Matters

Because it affects…

• Attitudes and beliefs about mental health
• Expression of symptoms
• Coping strategies
• Help-seeking behaviors
• Utilization of services
• Appropriateness of services and supports

Core Elements of a Culturally and Linguistically Competent System of Care

• Commitment from top leadership and agency resources
• Strategic plan with involvement of key diverse persons in a sustained, influential and critical advisory capacity
• Needs assessment and data collection (e.g. organizational self-assessment, evaluation/research activities that provide on-going feedback about progress, needs, modifications and next steps
• Mission statements, definitions, policies, and procedures reflecting the values and principles
• Recruitment and retention of diverse staff, including training and skill development
• Certification, licensure, and contract standards
• Targeted service delivery strategies.

System of Care: Operational Characteristics

- Collaboration across agencies
- Partnership with families and youth
- Cultural & linguistic competence
- Blended, braided, or coordinated financing
- Shared governance across systems & with families and youth
- Shared outcomes across systems
- Organized pathway to services & supports
- Child and family teams
- Staff, providers, families, youth trained and mentored in a common practice model
- Single plan of care
- One accountable care manager

- Cross-agency care coordination
- Individualized service/supports "wrapped around" child/youth & family
- Home- & community-based alternatives
- Broad, flexible array of services & supports
- Integration of clinical treatment services & natural supports, linkage to community resources
- Integration of evidence-based and promising treatment approaches
- Data-driven focus on CQI

Current Systems Problems

- Lack of home and community-based services and supports
- Patterns of utilization
- Cost
- Administrative inefficiencies
- Knowledge, skills and attitudes of key stakeholders
- Poor outcomes
- Financing structures
- Deficit-based/medical models, limited types of interventions

Fundamental Challenge and Rationale for Building Systems of Care

No one system controls everything.

Every system controls something.

## Characteristics of Systems of Care as Systems Reform Initiatives

<table>
<thead>
<tr>
<th>FROM</th>
<th>TO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fragmented service delivery</td>
<td>Coordinated service delivery</td>
</tr>
<tr>
<td>Categorical programs/funding</td>
<td>Blended resources</td>
</tr>
<tr>
<td>Limited services</td>
<td>Comprehensive service array</td>
</tr>
<tr>
<td>Reactive, crisis-oriented</td>
<td>Focus on prevention/early intervention</td>
</tr>
<tr>
<td>Focus on “deep end,” restrictive</td>
<td>Least restrictive settings</td>
</tr>
<tr>
<td>Children/youth out-of-home</td>
<td>Children/youth within families</td>
</tr>
<tr>
<td>Centralized authority</td>
<td>Community-based ownership</td>
</tr>
<tr>
<td>Creation of “dependency”</td>
<td>Creation of “self-help”</td>
</tr>
</tbody>
</table>

Frontline Practice Shifts

Control by professionals  Partnerships with families/youth
(I am in charge)  (acknowledging a power imbalance)
Only professional services  Partnership between natural and professional supports and services
Multiple case managers  One service coordinator
Multiple service plans  Single, individualized family plan (meeting needs of family)
(meeting needs of agency)
Family/youth blaming  Family/youth partnerships
Deficits focused  Strengths focused
Mono Cultural  Cultural Competence

Examples of Family Members and Youth Shifts in Roles and Expectations

Recipient of information re: child’s service plan
Passive partner in service planning process
Service planning team leader

Unheard voice in program evaluation
Participant in program evaluation
Partner (or independent) in developing and conducting program evaluations

Recipient of services
Partner in planning and developing services
Service providers

Uninvited key stakeholders in training initiatives
Participants in training initiatives
Partners and independent trainers

Anger, adversity & resistance
Self-advocacy
Advocacy & peer support

System Change/Transformation Focuses On…

- **Policy** Level (e.g., financing; regs; rates)
- **Management** Level (e.g., data; QI; HRD; system organization)
- **Frontline Practice** Level (e.g., assessment; care planning; care management; services/supports provision)
- **Community** Level (e.g., partnership with families, youth, natural helpers; community buy-in)

Categorical vs. Non-Categorical System Reforms

The Total Population of Children, Youth and Families Who Depend on Public Systems

- Children/youth/families eligible for Medicaid.
- Families who are not poor or uninsured and who exhaust their private insurance, often because they have a child with a serious emotional/behavioral challenge.
- Children/youth/families eligible for the State Children's Health Insurance Program (SCHIP).
- Poor and uninsured children/youth/families who do not qualify for Medicaid or SCHIP.
- Families who are not poor or uninsured and who may not yet have exhausted their private insurance but who need a particular type of service not available through their private insurer and only available from the public sector.
- Children/youth/families eligible for Tribal Authority funding.

Prevalence/Utilization Triangle

More complex needs

2 - 5% \( \{ \) Intensive Services – 60% of $$\)

15% \{ Accessible high-quality services and supports – 35% of $$\)

80% \{ Prevention and Universal Health Promotion – 5% of $$\)

Less complex needs

Example: Transition-Age Youth

What outcomes do we want to see for this population?

Policy Level
- What systems need to be involved? (e.g., Housing, Vocational Rehabilitation, Employment Services, Mental Health and Substance Abuse, Medicaid, Schools, Community Colleges/Universities, Physical Health, Juvenile Justice, Child Welfare)
- What dollars/resources do they control?

Management Level
- How do we create a locus of system management accountability for this population? (e.g., in-house, lead community agency)

Frontline Practice Level
- Are there evidence-based/promising approaches targeted to this population?
- What training do we need to provide and for whom to create desired attitudes, knowledge, skills about this population?
- What providers know this population best in our community? (e.g., culturally diverse providers)

Community Level
- What are the partnerships we need to build with youth and families?
- How can natural helpers in the community play a role?
- How do we create larger community buy-in?
- What can we put in place to provide opportunities for youth to contribute and feel a part of the larger community?
Building Local Systems of Care: Strategically Managing Complex Change

<table>
<thead>
<tr>
<th>Vision + Skills + Incentives + Resources + Action Plan</th>
<th>= CHANGE</th>
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</thead>
<tbody>
<tr>
<td>Vision + Skills + Incentives + Resources + Action Plan</td>
<td>= CONFUSION</td>
</tr>
<tr>
<td>Vision + Skills + Incentives + Resources + Action Plan</td>
<td>= ANXIETY</td>
</tr>
<tr>
<td>Vision + Skills + Incentives + Resources + Action Plan</td>
<td>= RESISTANCE</td>
</tr>
<tr>
<td>Vision + Skills + Incentives + Resources +</td>
<td>= FRUSTRATION</td>
</tr>
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Planning Structure Issues

- Leadership
- Staffing
- Time and place of meetings
- Stakeholder involvement
- Committees or work groups
- Communication or dissemination of information
- Outreach to broader constituencies
- Outreach to and involvement of diverse and disenfranchised constituencies
- Linkage to related reform/planning initiatives
- Resources

A Planning Process for Family and Children’s Service Reform

The System As It Is Now

Outcomes For Children

The System As It Should Be

Principles

Reinvestment Commitment

Financing Options

Combined Fiscal Program Strategy

Leadership and Professional Development Strategy

State County Community Cross Community Cross Agency

Governance Strategy

Multi Year Steps

Action Plan

Political Strategy

Elements of Effective Planning Processes

- Are staffed
- Involve key stakeholders
- Involve families and youth early in the process in ways that are meaningful
- Ensure meaningful representation of racially and ethnically diverse families and youth
- Develop and maintain a multi-agency focus
- Build on and incorporate related programmatic and planning initiatives
- Continually seek ways to build constituencies, interest, and investment
- Pay attention to sustainability and growth of system changes from day one

Strategies for Involving Families and Youth in the Planning

- Invitations and outreach flyers across agencies, i.e., family organizations, home visiting programs, health clinics, family preservation, community.
- Engage families/youth who work regularly with other families and youth.
- Contract with family organizations and community-based organizations to develop/sustain process for providing participant supports.
- Offer stipends, transportation, food, child care, interpretation and translation.
- Hold planning meetings at flexible times, i.e., evenings or on weekends, accessible locations.
- Conduct focus groups, interviews and surveys.
- Provide ongoing training and mentoring.
- Have more than token representation.
- Conduct sessions for planning group members with trained facilitators to explore attitudes about race, culture, families.
- Publicly acknowledge the contributions of families and youth.

Strategies for Addressing Cultural and Linguistic Competence in Planning

• Engage the community in building support for change (e.g. conducting on-going assessments of the environment)
• Identify, engage and partner with formal and informal community leaders and cultural brokers
• Provide mentoring and partnership opportunities
• Partner to establish and articulate values, mission, and goals and action steps
• Provide culturally and linguistically appropriate invitations, outreach materials, and other information
• Be prepared, be respectful

Lazear, K. University of South Florida. Primer Hands On (2008)
Cuyahoga County Planning Process Structure

System of Care Oversight Committee
Chaired by Deputy County Administrator for Human Services
Includes a Broad Representative Stakeholder Group, e.g., major child serving systems, families and youth, Neighborhood Collaboratives, providers, researchers

- Cultural & Linguistic Competence
- Family & Youth Involvement
- Social Marketing
- Evaluation & Research
- Design & Sustainability
- Training & Coaching

Staffed by
System of Care Office

## Factors Influencing Group Process

<table>
<thead>
<tr>
<th>Participation</th>
<th>Maintenance Functions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influence</td>
<td>Group Atmosphere</td>
</tr>
<tr>
<td>Styles of Leadership</td>
<td>Membership</td>
</tr>
<tr>
<td>Decision-Making Procedures</td>
<td>Feelings</td>
</tr>
<tr>
<td>Task Functions</td>
<td>Norms</td>
</tr>
</tbody>
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Adapted from The Pheiffer Book of Successful Team-Building Tools, Edited by Elaine Biech. Copyright 2001 by John Wiley & Sons, Inc.
Coming together is a beginning.
Keeping together is progress.
Working together is success.

H. Ford

Process
How system builders conduct themselves

Structure
What gets built (i.e., how functions are organized)

Core Elements of an Effective System-Building Process

The Importance of Leadership & Constituency Building

- A core leadership group
- Evolving leadership
- Effective collaboration
- Partnership with families and youth
- Cultural and linguistic competence
- Connection to neighborhood resources and natural helpers
- Bottom-up and top-down approach
- Effective communication
- Conflict resolution, mediation, and team-building mechanisms
- A positive attitude

Core Elements of an Effective System-Building Process

The Importance of Being Strategic

- A strategic mindset
- A shared vision based on common values and principles
- A clear population focus
- Shared outcomes
- Community mapping—understanding strengths and needs
- Understanding and changing traditional systems
- Understanding of the importance of “de facto” mental health providers (e.g., schools, primary care providers, day care providers, head start)
- Understanding of major financing streams
- Connection to related reform initiatives
- Clear goals, objectives, and benchmarks
- Trigger mechanisms—being opportunistic
- Opportunity for reflection
- Adequate time

Partnership/Collaboration Involves

- Team Building
- Communication
- Negotiations
- Conflict Resolution
- Leadership Development
- Mutual Respect
- Skill Building
- Information Sharing

## Challenges to Collaboration “Barrier Busters”

<table>
<thead>
<tr>
<th>CHALLENGE</th>
<th>BARRIER BUSTERS</th>
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</thead>
</table>
| Language differences: Mental health jargon vs. court jargon | • Cross training  
• Share each other’s turf  
• Share literature |
| Role definition: “Who’s in charge?” | • Family driven/accountability  
• Team development training  
• Job shadowing  
• Communication channels  
• Share myths and realities |
| Information sharing among systems | • Set up a common data base  
• Share organizational charts/phone lists  
• Share paperwork  
• Promote flexibility in schedules to support attendance in meetings |
| Addressing issues of community safety | • Document safety plans  
• Develop protocol for high-risk kids  
• Demonstrate adherence to court orders  
• Maintain communication with District Attorneys  
• Myths of “bricks and mortar” |
| Maintaining investment from stakeholders | • Invest in relationships with partners in collaboration  
• Share literature and workshops  
• Track and provide meaningful outcomes |
| Sharing value base | • Infuse values into all meetings, training, and workshops  
• Share documentation and include parents in as many meetings as possible  
• Strength-based cross training  
• Develop QA measures based on values |

Structure

“Something Arranged in a Definite Pattern of Organization”

I. Distributes
   – Power
   – Responsibility

II. Shapes and is shaped by
    – Values

III. Affects
    – Practice and outcomes
    – Subjective experiences
      (i.e., how participants feel)

Figure 1A: State Mental Health Department

- Department Director
- Division of Institutions
  - State Hospital Units
  - Residential Treatment Facilities
- Division of Community Programs
  - Adult Community Support Programs
  - Community Mental Health Centers (CMHCS)
- Division of Special Populations
  - Elderly
  - Children & Adolescents
  - Demonstration Projects
  - Local CMHS Grants
- Child & Adolescent Subcommittee
  - Statewide Family Organization Chair as member
- State Mental Health Advisory Council

Figure 1B: State Mental Health Department

- Department Director
- Division of Adult Programs
- Division of Child-Adolescent Programs
  - Continuum of Care for Children
- Grant to Statewide Family Organization
  - Support for Local Family Organizations
- Division of Forensic Programs

System of Care Functions Requiring Structure

- Planning
- Decision Making/Policy Level Oversight
- System Management
- Benefit Design/Service Array
- Evidence-Based Practice
- Outreach and Referral
- System Entry/Access
- Screening, Assessment, and Evaluation
- Decision Making and Oversight at the Service Delivery Level
  - Care Planning
  - Care Authorization
  - Care Monitoring and Review
- Care Management or Care Coordination
- Crisis Management at the Service Delivery and Systems Levels
- Utilization Management
- Family Involvement, Support, and Development at all Levels
- Youth Involvement, Support, and Development at all Levels
- Cultural and Linguistic Competence
- Staffing Structure
- Staff Involvement, Support, Development
- Orientation, Training of Key Stakeholders
- External and Internal Communication
- Provider Network
- Protecting Privacy
- Ensuring Rights
- Transportation
- Financing
- Purchasing/Contracting
- Provider Payment Rates
- Revenue Generation and Reinvestment
- Billing and Claims Processing
- Information Management
- Quality Improvement
- Evaluation
- System Exit
- Technical Assistance and Consultation

Definition of Governance

Decision making at a policy level that has legitimacy, authority, and accountability.

Definition of System Management

Day-to-day operational decision making

Key Issues for Governing Bodies

☑ Has authority to govern
☑ Is clear about what it is governing
☑ Is representative
☑ Has the capacity to govern
☑ Has the credibility to govern
☑ Assumes shared liability across systems for target population

Examples of Types of Governance Structures

- State and/or local interagency body
- Non profit board of directors
- Quasi governmental entity
- Tribal governance
- Hybrids

Evolving Governance Structure

Illustration 1.2A

Policy Level ←→ Local Governing Board ←→ Agency Directors
Family Advocacy
Organizational Representative

Operational Level ←→ DMH Director

“Bring the Children Home”
SOC Supervisor and Staff

“Bring the Children Home”
Case Managers

Illustration 1.2B

BRING THE CHILDREN HOME STATE LEGISLATION

COUNTY EXECUTIVE

Local Governing Board ←→ SOC Team Leader

“Bring the Children Home”
Interagency Care Management Team

“Bring the Children Home”
Care Managers

Agency Directors
Family/Youth Reps.
DMH Director

Providers Forum

Families/Youth Served
Other Agency Workers

Families Served
Other Agency Workers

System Management: Day-to-Day Operational Decision Making

Key Issues

• Is the reporting relationship clear?
• Are expectations clear regarding what is to be managed and what outcomes are expected?
• Does the system management structure(s) have the capacity to manage?
• Does the system management structure(s) have the credibility to manage?
Examples of Types of System Management Structures

• State and/or local interagency body
• Quasi-governmental entity
• Non profit lead agency
• Public sector lead agency
• For profit commercial managed care entity
• Shared management structure/hybrid

NJ Children’s System of Care Initiative

Screening with Uniform Protocols

Contracted Systems Administrator CSA
- Registration
- Screening for self-referrals
- Tracking
- Assessment of Level of Care Needed
- Care Coordination
- Authorization of Services

CMO
- Complex Multi-System Children
- ISP Developed
- Full Plan of Care Authorized

FSO
Family to Family Support

Community Agencies
- Uncomplicated Care
- Service Authorized
- Service Delivered

Family & Self

Other

School Referral

Community Agencies

Child Welfare

JJC Court
Arizona System of Care
Maricopa County Example

ADHS/BHS

MiKid

RBHA in Maricopa – BHO

Family Involvement Center

Youth Movement

Comprehensive Service Providers

Community Service Agencies
Wraparound Milwaukee

**Child Welfare**
Funds thru Case Rate
(Budget for Institutional Care for CHIPS Children)

9.5M

**Juvenile Justice**
(Funds Budgeted for Residential Treatment for Delinquent Youth)

8.5M

**Medicaid Capitation**
(1557 per Month per Enrollee)

10M

**Mental Health**
• Crisis Billing
• Block Grant
• HMO Commercial Insurance

2.0M

**Management Entity:**
Wraparound Milwaukee
Management Service Organization (MSO)
$30M

**Per Participant Case Rate**

**Care Coordination**

**Child and Family Teams**

**Plans of Care**

**Provider Network**
240 Providers
85 Services

**Family Organization**
$300,000

**Mgt. Entity:** Co. BH Div.
Example of Governance/Management Structure

State Interagency Body

State Funding Pool

Financer/Payers

Local Allocation

Purchaser

County Alliance

Care Management Entity

- Organize and manage provider network
- Staff and manage child and family team process
- Care management, including case management and utilization management/utilization review
- Quality assurance
- Outcomes management/monitoring
- Management Information System (tracks children, services, dollars)

Case Rate for each enrolled child

Provider

Provider

Provider

Example of Governance/Management Structure

BRING THE CHILDREN HOME STATE LEGISLATION

COUNTY EXECUTIVE

Local Governing Board

SOC Team Leader

“Bring the Children Home” Interagency Care Management Team

“Bring the Children Home” Care Managers

Agency Directors Family/Youth Reps. DMH Director

Providers Forum

Families/Youth Served Other Agency Workers

Examples of Types of Family/Youth Partnership in System Governance and Management

• Input/evaluation of key management
• Input/evaluation of quality of services and programs
• Local system of care input
• Resource allocation
• Service planning and implementation
• Policies and procedures
• Grievance and resolution procedures

CLC: Governance Level

Role and Responsibility: Develop a governance structure that ensures a CLC system of care.

Examples of Activities
- identify, recruit and select members of the governing body and CLC Committee that are reflective of the population of focus
- create and/or revise mission statement, policies to affirm support of CLC perspective
- conduct annual organizational assessment, demographic analysis and needs assessment
- allocate adequate funds
- develop formal partnerships with cultural community agencies, faith-based entities, traditional cultural providers, other cultural relevant organizations
- develop strategies to support and retain diverse board members, i.e. mentoring and partnering
- develop a policy for timely provision of interpretation services and allocation of bilingual staff
- develop policy for reimbursement of services provided by youth and families on boards, committees, outreach services

Adapted from Sample Cultural and Linguistic Competency Plan (2008) Technical Assistance Partnership: www.tapartership.org/cc
CLC: Management Level

Role and Responsibility: Develop an organizational structure and administrative guidelines to ensure a CLC management structure.

Examples of Activities
- organize CLC committee and provide with the authority to monitor service delivery
- assess and modify the physical facility to reflect the population of focus
- locate services geographically accessible and acceptable
- recruit and hire youth and their families reflecting the diversity at all levels of the system of care
- review and modify job descriptions to include requirements for development of cultural knowledge and cross-cultural practice skills
- conduct annual organizational cultural and linguistic competence self-assessment
- establish a plan for retention of diverse workforce

Adapted from Sample Cultural and Linguistic Competency Plan (2008) Technical Assistance Partnership: www.tapartnership.org/cc
Outreach and Engagement Issues

- Who is it we are trying to reach?
- How will we reach and engage the population of focus and subsets within it?
- How will we structure outreach to culturally and linguistically diverse constituencies?
- How will we partner with families, youth, and culturally diverse constituencies in reaching out to different populations of focus?
- Who are other constituencies we need to engage, such as judges, legislators, other systems

Referral Issues

- Who can refer?
- Can families and youth self-refer?
- Where are referrals made?
- Will the system have a narrow or broad referral base?
- Will there be waiting lists?
- What role will families, youth, family and youth organizations, and culturally and linguistically diverse constituencies play in the referral process?

Organized Pathway to Care

Multiple Entry Points
+ more accessible
- loss of entry control
- loss of quality control
+
-

One Access Point
+ less confusing
+ more entry control
- inaccessible
-
-

Can create virtual single pathway through integrated MIS

Examples of Pathways to Care for Families

Cuyahoga County, OH

11 Neighborhood Collaboratives + Lead Provider Agencies

County MIS System

Milwaukee Wraparound

Milwaukee County, WI

Example of a Family’s Pathway to Care

Time and Travel
(Ten Month Period)

- **Study Family**
- **Comparison Family**

<table>
<thead>
<tr>
<th></th>
<th>Study Family</th>
<th>Comparison Family</th>
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</thead>
<tbody>
<tr>
<td>Number of Scheduled Office Visits</td>
<td>69:6</td>
<td>69:6</td>
</tr>
<tr>
<td>Number of Hours Spent in Office Visits</td>
<td>105:8</td>
<td>105:8</td>
</tr>
<tr>
<td>Number of Hours Spent Traveling to and from Office Visits</td>
<td>29:6</td>
<td>29:6</td>
</tr>
<tr>
<td>Number of Miles Traveled for Care</td>
<td>1250:180</td>
<td>1250:180</td>
</tr>
</tbody>
</table>
Example of Community Outreach and Engagement
Everglades Health Center, Dade County, FL

• Signs in 3 languages: Spanish, English, and Creole Haitian
• Literacy programs
• Audio cassettes in Spanish, English, Creole, Honduran dialect, 3 Mexican dialects, 2 Guatemalan dialects
• Mini soap operas for the radio (with follow-up by health care workers going in homes and community centers)
Example of Community Outreach & Engagement
Abriendo Puertas Family Center, East Little Havana, Miami, FL

- Governing board composed of 51% residents;
- Family Council to nurture leadership in decision-making;
- Natural helpers (Madrinas/Padrinos) to provide informal supports;
- Time Dollar Bank barter program to track volunteer hours given in exchange for services received;
- Extensive collaboration among providers, including co-location of services to create a continuum of service and supports;
- Frontline practice service delivery approach (EQUIPO) that partners natural helpers with formal service providers;
- Family Resource Center as the hub for accessing services and supports and for promoting the development of social support networks among neighborhood families.

Example of Outreach and Engagement
Family Support Organization, Burlington County, NJ

Book Club initially created by the Family Support Organization to confront issues associated with serving sexual minority (GLBTQI) youth.

Cultural Competence Committee of the Burlington Partnership System of Care shares/supplies books with community, uses a facilitator, creates a book club structure and meets throughout the community

Roles for Families & Youth in Outreach, Engagement, Referral

- Building formal and informal environments of trust (focus groups, education forums, support and social events, etc.).

- Contracting to provide outreach, support and education services to assist systems in understanding population needs and diverse cultures.

- Creating methods for families and youth to connect with each other for information (phone trees, list serves, chat rooms, newsletters, social events, etc.)

- Sponsoring conferences and summits; designing and delivering workshops to create bridges of confidence between families, youth and the system.
Distinctions Among Screening, Assessment and Evaluation, and Care Planning

**Screening**: 1\(^{st}\) step, triage, identify children at high risk, link to appropriate assessments

**Assessment**: Based on data from multiple sources; Comprehensive; Identify strengths, resources, needs; Leads to care planning

**Evaluation**: Discipline-specific, e.g., neurological exam; Closer, more intensive study of a particular or suspected clinical issue; Provides data to assessment process

**Care Planning**: Individualized decision making process for determining services and supports; Draws on screening, assessment, and evaluation data

Problem Oriented to Strengths-Based Approach

A Problem Paradigm

1. Assessment focused on problems, strengths minimized. Perception as deficient or incompetent (may include cultural or racial bias)

2. "Client/patient" treated as recipient of services, undermining of previous skills and resourcefulness

3. Reinforcement of self-identification as sick, inadequate, or weak

4. Promotion of dependency on formal services, increasing isolation from informal services

A Empowerment Paradigm

1. Assessment of strengths and stresses, affirmation of resourcefulness, help-seeking supported

2. Reduced susceptibility to stress overload

3. Professional emphasizes collaboration in addressing stresses, interdependence

4. Self/other labeling as able

5. Buildup and maintenance of coping skills

6. Internalization of self-view as effective

(Develop internal locus of control, build adaptive problem-solving, enlarge circle of support, pride for culture)

Wraparound is a practice approach that can be applied to any population of children and families with or at risk for intensive service needs – not just to those with the most serious and complex problems.

Wraparound puts system of care values and principles into practice for service planning and provision.

Supportive Environment for Effective Wraparound in a System of Care

Hospitable System
(policy and funding context)

Supportive Organization
(lead and partner agencies)

Child and Family Team Utilizing a Wraparound Approach

Definition of Wraparound

Wraparound is “a definable planning process that results in a unique set of community services and natural supports that are individualized for a child and family to achieve a positive set of outcomes.”

Phases of Wraparound

Engagement and team preparation

Plan development

Implementation

Transition

Time

www rtc pdx edu/nwi

Bruns, E. Ensuring high quality wraparound
Why and How Does Wraparound Work

Life Domain Areas

Eco-Mapping

- Exercise Partners/Compañeros de ejercicio
- Work/Trabajo
- Health Care/Servicios de Salud
- Extended Family/Familiares
- Friends/Amigos
- Social Services/Servicios Sociales
- Neighbors/Vecinos
- School/Escuela
- Faith Organizations/Organizaciones religiosas

Strong connections
Tenuous connections
Stressful connections
Flow of energy

Orrego, M.E. Lazear, K. J. EQUIPO: University of South Florida, Tampa, FL
Adapted from Markiewicz, J. Eco-Map
A Well Documented Service and Support Plan…

• Respectfully, thoughtfully documents the family’s experience.
• Is written from strengths, addresses culture and linguistics.
• Uses the family’s and youth’s own words to create a family vision.
• Identifies needs that moves the family closer to their vision.
• Identifies strength-based, creative and practical strategies to meet the chosen needs; addresses mandates while staying family-driven and youth-guided.
• Articulates a crisis/safety plan that moves from least restrictive (most normative) to more restrictive.
• Attends to transition out of the formal wraparound process.
• Includes all necessary signatures of participation and commitment.
• Reflects what was said in the child and family team meeting.

Poor Plans…

• Build a system-based team rather than a family-based team
• Lack community and natural supports
• Fail to meet parent’s needs along with the child’s/youth’s needs
• Emphasize compliance rather than support of needs being met
• Neglect to develop strategies based on strengths
• Lack creativity and responsible risk taking
• Lack cultural awareness
• Over-rely on an existing categorical service
• Neglect crisis planning throughout the process
• Create power struggles with families, youth or systems
• Throw money at the problem
What Wraparound is Not

• A system of care
• A new funding source
• A “service”
• A way to get “stuff” – services that are not typically reimbursable
• Only for a small group of kids
• Case management
• A specific intervention or program
• A categorical approach where services reflect what’s available rather than what’s really needed

Example of Using Both Family Group Decision Making and Wraparound Kansas Child Welfare System

Family Group Decision Making

All children in child welfare

Wraparound

Children with intensive needs

Website for the National Wraparound Initiative

www.rtc.pdx.edu/nwi

Types of Services in Systems of Care

- Assessment and diagnosis
- Outpatient psychotherapy
- Medical management
- Home-based services
- Day treatment/partial hospitalization
- Mobile crisis/stabilization services
- Behavioral aide services
- Therapeutic foster care
- Therapeutic group homes
- Residential treatment centers
- Crisis residential services
- Inpatient hospital services
- Case management services
- School-based services
- Respite services
- Wraparound
- Family support/education
- Youth peer support
- Transportation
- Mental health consultation
- Early intervention and prevention services
- Other, specify

# Dawn Services & Supports

<table>
<thead>
<tr>
<th><strong>Behavioral Health</strong></th>
<th><strong>Psychiatric</strong></th>
<th><strong>Other</strong></th>
<th><strong>Discretionary</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavior management</td>
<td>Assessment</td>
<td>Camp</td>
<td>Activities</td>
</tr>
<tr>
<td>Crisis intervention</td>
<td>Medication follow-up/psychiatric review</td>
<td>Team meeting</td>
<td>Automobile repair</td>
</tr>
<tr>
<td>Day treatment</td>
<td>Nursing services</td>
<td>Consultation with other professionals</td>
<td>Childcare/supervision</td>
</tr>
<tr>
<td>Evaluation</td>
<td></td>
<td>Guardian ad litem</td>
<td>Clothing</td>
</tr>
<tr>
<td>Family assessment</td>
<td></td>
<td>Transportation</td>
<td>Educational expenses</td>
</tr>
<tr>
<td>Family preservation</td>
<td></td>
<td>Interpretive services</td>
<td>Furnishings/appliances</td>
</tr>
<tr>
<td>Family therapy</td>
<td></td>
<td></td>
<td>Housing (rent, security deposits)</td>
</tr>
<tr>
<td>Group therapy</td>
<td></td>
<td></td>
<td>Medical</td>
</tr>
<tr>
<td>Individual therapy</td>
<td></td>
<td></td>
<td>Monitoring equipment</td>
</tr>
<tr>
<td>Parenting/family skills training</td>
<td>Life coach/independent living skills mentor</td>
<td></td>
<td>Paid roommate</td>
</tr>
<tr>
<td>Substance abuse therapy, individual and group</td>
<td>Parent and family mentor</td>
<td></td>
<td>Supplies/groceries</td>
</tr>
<tr>
<td>Special therapy</td>
<td></td>
<td></td>
<td>Utilities</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Placement</strong></th>
<th><strong>Mentor</strong></th>
<th><strong>Respite</strong></th>
<th><strong>Service Coordination</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute hospitalization</td>
<td>Community case management/case aide</td>
<td>Crisis respite</td>
<td>Case management</td>
</tr>
<tr>
<td>Foster care</td>
<td>Clinical mentor</td>
<td>Planned respite</td>
<td>Service coordination</td>
</tr>
<tr>
<td>Therapeutic foster care</td>
<td>Educational mentor</td>
<td>Residential respite</td>
<td>Intensive case management</td>
</tr>
<tr>
<td>Group home care</td>
<td>Life coach/independent living skills mentor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relative placement</td>
<td>Parent and family mentor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residential treatment</td>
<td>Recreational/social mentor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shelter care</td>
<td>Supported work environment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crisis residential</td>
<td>Tutor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supported independent living</td>
<td>Community supervision</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2005 CHIOCES, Inc., Indianapolis, IN
Evidence-based practices: *Show evidence of effectiveness through carefully controlled scientific studies, including random clinical trials. Examples include:*
- Multisystemic Therapy (MST)
- Multidimensional Treatment Foster Care (MDTFC)
- Functional Family Therapy (FFT)
- Cognitive Behavioral Therapy (various models)
- Intensive Case Management (various models)

Promising approaches or Practice-Based Evidence: *Show evidence of effectiveness through experience of key stakeholders (e.g., families, youth, providers, administrators) and outcomes data. Examples include:*
- Family Support and Education
- Wraparound Approach
- Mobile Response and Stabilization Services
- Family Group Conferencing

Effectiveness Research
(Barbara Burns’ Research at Duke University)

• Most evidence of efficacy: Intensive case management, in-home services, therapeutic foster care

• Less evidence (because not much research done): Crisis services, respite, mentoring, family education and support

• Least evidence (and lots of research): Inpatient, residential treatment, therapeutic group home

Examples of What You’d Want to Provide Based on Effectiveness Literature

**Outpatient Models**
- Cognitive Behavior Therapy (various models)
- Functional Family Therapy (FFT)
- Parent Child Interaction Therapy (PCIT)

**Intensive In-Home Models**
- Multisystemic Therapy (MST)

**Out-of-Home Model**
- Multidimensional Treatment Foster Care
- Intensive Care Management

Examples of Other Home and Community-Based Services You’d Want to Provide Based on Practice, Family, and Youth Experience & Outcomes Data

- Intensive in-home services (not just Multisystemic Therapy-MST)
- Child and youth respite services
- Mobile response and stabilization services
- Mental health consultation services
- Independent living skills and supports
- Family and youth education and peer support
Examples of What You Don’t See Listed as Evidence-Based Practice
(though they may be standard practice)

• Traditional office-based “talk” therapy
• Residential Treatment
• Group Homes
• Day Treatment


### Examples from Hawaii’s List of Evidence Based Practices

<table>
<thead>
<tr>
<th>Problem Area</th>
<th>Best Support</th>
<th>Good Support</th>
<th>Moderate Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxious or Avoidant Behaviors</td>
<td>Cognitive Behavior Therapy (CBT); Exposure Modeling</td>
<td>CBT with Parents; Group CBT; CBT for Child &amp; Parent; Educational Support</td>
<td>None</td>
</tr>
<tr>
<td>Depressive or Withdrawn Behaviors</td>
<td>CBT</td>
<td>CBT with Parents; Inter-Personal Tx. (Manualized); Relaxation</td>
<td>None</td>
</tr>
<tr>
<td>Disruptive &amp; Oppositional Behaviors</td>
<td>Parent &amp; Teacher Training; Parent Child Interaction Therapy</td>
<td>Anger Coping Therapy; Assertiveness Training; Problem Solving Skills Training, Rational Emotive Therapy, AC-SIT, PATHS &amp; FAST Track Programs</td>
<td>Social Relations Training; Project Achieve</td>
</tr>
<tr>
<td>Juvenile Sex Offenders</td>
<td>None</td>
<td>None</td>
<td>Multisystemic Therapy</td>
</tr>
<tr>
<td>Delinquency &amp; Willful Misconduct Behavior</td>
<td>None</td>
<td>Multisystemic Therapy; Functional Family Therapy</td>
<td>Multi-Dimensional Treatment Foster Care; Wraparound Foster Care</td>
</tr>
<tr>
<td>Substance Use</td>
<td>CBT</td>
<td>Behavior Therapy; Purdue Brief Family Therapy</td>
<td>None</td>
</tr>
</tbody>
</table>

Families’ and Youth’s Roles in Building Evidence-Based Practice (EBP)

• Advocate for ethical, culturally sensitive research.
• Participate in the development and analysis of research to support EBP.
• Assist in data collection to support EBP and learn to use it to guide decisions.
• Educate yourself and ask for information when needed. Ask questions.

Consensus Statement on Evidence-Based Programs (EBP) and Cultural Competence

• Evidence exists that shows that specific programs are effective for specific populations in specific settings.
• Helpful practices exist for which “evidence” has not been fully established.
• Little research on EBPs has been conducted on diverse populations.
• Implementation of EBPs depends on adequate infrastructure.
• Emergent research suggests that adaptations can be made for specific populations.

Service Array Focused on a Total Population

Universal

- Family Support Services
- Youth Development Program/Activities
- Coordinated Intake Assessment & Treatment Planning
- Service Coordination
- Intensive Care Management
- Clinical Services

Targeted

- Prevention
- Early Intervention
- Intensive Services

Developing a Culturally and Linguistically Competent Service Array

- Is the service array driven by family-preferred choices?
- Does the service array reflect the needs/help-seeking behaviors of youth & families?
- Does the service array reflect principles of equal access/non-discriminatory practices?
- Is the service array tailored or matched to the unique needs of children, youth, families, organizations and communities served?
- Does the service array recognize mental health as integral and inseparable from primary health care?
- Does the service array reflect cultural competence regarding Evidence Based Practices (EBP), and does it consider Practice Based Evidence (PBE) as a critical component of EBPs in communities of color?
Where Families, Youth and Family and Youth Organizations Fit Into the Service Array

<table>
<thead>
<tr>
<th>As technical assistance providers &amp; consultants</th>
<th>As direct service providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ Training</td>
<td>➢ Family Liaisons</td>
</tr>
<tr>
<td>➢ Evaluation</td>
<td>➢ Care Coordinators</td>
</tr>
<tr>
<td>➢ Research</td>
<td>➢ Family Educators</td>
</tr>
<tr>
<td>➢ Support</td>
<td>➢ Specific Program Managers (respite, etc)</td>
</tr>
<tr>
<td>➢ Outreach/Dissemination</td>
<td>➢ Youth Peer Mentors</td>
</tr>
</tbody>
</table>

Examples of Strategies to Address Lack of Home and Community-Based Services

• Support family and youth movements
• Engage natural helpers and culturally diverse communities
• Implement a meaningful Medicaid rehab option
• Write child-appropriate service definitions
• Collapse out-of-home and home and community-based budget structures
• Re-direct dollars from “deep end” to home and community-based
• Implement flexible rate structures (e.g., bundled rates/case rates)
• Implement pilots or phase in system change

(continued)

Examples of Strategies to Address Lack of Home and Community-Based Services (continued)

• Implement capacity-building grants
• Implement performance-based contracts
• Develop practice and implementation guidelines
• Train providers, judges, families, youth etc. – use training resources across systems
• Implement quality and utilization management
• Apply for federal demos (e.g., CMHS, ACF, CMS, CSAT)
• Collect data on children’s outcomes, family/youth satisfaction, and cost/benefits
• Educate key constituencies (e.g., legislators, Governor’s Office, State Insurance Commissioner)

Implications for How RTCs Are Utilized

• Movement away from “placement” orientation and long lengths of stay
• Residential as part of an integrated continuum, connected to community
• Shared decision making with families/youth and other providers and agencies
• Individualized treatment approaches through a child and family team process
• Incorporation of SOC values/principles in RTC practice

For more information, go to Building Bridges Initiative:
1) www.systemsofcare.samsha.gov
2) Click on Hot Topics
3) Click on Issues in Residential Treatment
Examples of Sources of Funding for Children/Youth with Behavioral Health Needs in the Public Sector

<table>
<thead>
<tr>
<th>Medicaid</th>
<th>Mental Health</th>
<th>Education</th>
<th>Tribal Authority Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Medicaid In-Patient</td>
<td>• MH General Revenue</td>
<td>• ED General Revenue</td>
<td></td>
</tr>
<tr>
<td>• Medicaid Outpatient</td>
<td>• MH Medicaid Match</td>
<td>• ED Medicaid Match</td>
<td></td>
</tr>
<tr>
<td>• Medicaid Rehabilitation</td>
<td>• MH Block Grant</td>
<td>• Student Services</td>
<td></td>
</tr>
<tr>
<td>Services Option</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Medicaid Early Periodic</td>
<td>• Child Welfare</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screening, Diagnosis and</td>
<td>• CW General Revenue</td>
<td>• JJ General Revenue</td>
<td></td>
</tr>
<tr>
<td>Treatment (EPSDT)</td>
<td>• CW Medicaid Match</td>
<td>• JJ Medicaid Match</td>
<td></td>
</tr>
<tr>
<td>• Targeted Case Management</td>
<td>• IV-E (Foster Care and Adoption Assistance)</td>
<td>• JJ Federal Grants</td>
<td></td>
</tr>
<tr>
<td>• Medicaid Waivers</td>
<td>• IV-B (Child Welfare Services)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• TEFRA Option</td>
<td>• Family Preservation/Family Support</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Substance Abuse</th>
<th>Juvenile Justice</th>
<th>Other</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• SA General Revenue</td>
<td>• JJ General Revenue</td>
<td>• WAGES</td>
<td></td>
</tr>
<tr>
<td>• SA Medicaid Match</td>
<td>• JJ Medicaid Match</td>
<td>• Children’s Medical Services/Title V– Maternal and Child Health</td>
<td></td>
</tr>
<tr>
<td>• SA Block Grant</td>
<td>• JJ Federal Grants</td>
<td>• Mental Retardation/ Developmental Disabilities</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Title XXI-State Children’s Health Insurance Program (SCHIP)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Vocational Rehabilitation</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Supplemental Security Income (SSI)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Local Funds</td>
<td></td>
</tr>
</tbody>
</table>

Where to Look for Money and Other Types of Support

**Government**
Federal, State, County, City

**Foundations**
National, Regional, Community, Family

**Individuals**
Contributions or Users Fees

**Service Clubs**
e.g., Kiwanis, junior League, Lions

**Income Generating Activities**
e.g., Youth-run business

**System of Care**

**Business**
Corporate Giving Programs or Small Business

**Taxes and Levies**
State and County

**3rd Part Reimbursement**

**Churches**

**Unions**

---

## Diversity of CMHS Grant Site Funding

<table>
<thead>
<tr>
<th>SOURCE</th>
<th>SYSTEM</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>State</strong></td>
<td>Mental Health</td>
<td>General fund, Medicaid (include FFS/managed care/waivers), federal mental health block grant, redirected institutional funds, funds allocated as a result of court decrees</td>
</tr>
<tr>
<td><strong>Child Welfare</strong></td>
<td></td>
<td>Title IV-B (family preservation), Title IV-B (foster care services), Title IV-E (adoption assistance, training, administration), technical assistance, in-kind staff resources</td>
</tr>
<tr>
<td><strong>Juvenile Justice</strong></td>
<td></td>
<td>Federal formula grant funds to states for juvenile justice prevention, state juvenile justice appropriations, and juvenile courts</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td>Special education, general education, training, technical assistance, and in-kind staff resources</td>
</tr>
<tr>
<td><strong>Governor’s Office/Cabinet</strong></td>
<td></td>
<td>Special children’s initiatives, often including interagency blended funding</td>
</tr>
<tr>
<td><strong>Social Services</strong></td>
<td></td>
<td>Title XX funds and realigned welfare funds (TANF)</td>
</tr>
<tr>
<td><strong>Bureau of Children with Special Needs</strong></td>
<td></td>
<td>Title V federal funds and state resources</td>
</tr>
<tr>
<td><strong>Health Dept.</strong></td>
<td></td>
<td>State funds</td>
</tr>
<tr>
<td><strong>Public Universities</strong></td>
<td></td>
<td>In-kind support, partner in activities</td>
</tr>
<tr>
<td><strong>Dept. of Children</strong></td>
<td></td>
<td>In states where child mental health services are the responsibility of child agency, not mental health, sources of funds similar to above</td>
</tr>
<tr>
<td><strong>Voc. Rehab.</strong></td>
<td></td>
<td>Federal- and state-supported employment funds</td>
</tr>
<tr>
<td><strong>Housing</strong></td>
<td></td>
<td>Various sources</td>
</tr>
</tbody>
</table>
### Diversity of CMHS Grant Site Funding (continued)

<table>
<thead>
<tr>
<th>SOURCE</th>
<th>SYSTEM</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Local</strong></td>
<td>County, City, or Local Township</td>
<td>General fund</td>
</tr>
<tr>
<td></td>
<td>Juvenile Justice</td>
<td>Locally controlled funds</td>
</tr>
<tr>
<td></td>
<td>Education</td>
<td>Courts, probation department, and community corrections</td>
</tr>
<tr>
<td></td>
<td>County</td>
<td>May levy tax for specific purposes (mental health)</td>
</tr>
<tr>
<td></td>
<td>Food Programs</td>
<td>In-kind donations of time and food</td>
</tr>
<tr>
<td></td>
<td>Health</td>
<td>Local health authority-controlled resources</td>
</tr>
<tr>
<td></td>
<td>Public Universities/Community Colleges</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Substance Abuse</td>
<td>In-kind support</td>
</tr>
<tr>
<td><strong>Private</strong></td>
<td>Third Party Reimbursement</td>
<td>Private insurance and family fees</td>
</tr>
<tr>
<td></td>
<td>Local Businesses</td>
<td>Donations and in-kind support</td>
</tr>
<tr>
<td></td>
<td>Foundations</td>
<td>Robert Wood Johnson, Annie E. Casey, Soros Foundation, and various local foundations</td>
</tr>
<tr>
<td></td>
<td>Charitable</td>
<td>Lutheran Social Services, Catholic Charities, faith organizations, homeless programs, food programs (in-kind)</td>
</tr>
<tr>
<td></td>
<td>Family Organizations</td>
<td>In-kind Support</td>
</tr>
</tbody>
</table>

## Financing Strategies to Support Improved Outcomes for Children, Youth and Families

**FIRST PRINCIPLE: System Design Drives Financing**

<table>
<thead>
<tr>
<th>REDEPLOYMENT</th>
<th>REFINANCING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Using the money we already have</td>
<td>Generating new money by increasing federal claims</td>
</tr>
<tr>
<td>The cost of doing nothing</td>
<td>The commitment to reinvest funds for families and children</td>
</tr>
<tr>
<td>Shifting funds from treatment to prevention</td>
<td>Foster Care and Adoption Assistance (Title IV-E)</td>
</tr>
<tr>
<td>Moving across fiscal years</td>
<td>Medicaid (Title XIX)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RAISING OTHER REVENUE TO SUPPORT FAMILIES AND CHILDREN</th>
<th>FINANCING STRUCTURES THAT SUPPORT GOALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Donations</td>
<td>Seamless services: Financial claiming invisible to families</td>
</tr>
<tr>
<td>Special taxes and taxing districts for children</td>
<td>Funding pools: Breaking the lock of agency ownership of funds</td>
</tr>
<tr>
<td>Fees &amp; third party collections including child support</td>
<td>Flexible Dollars: Removing the barriers to meeting the unique needs of families</td>
</tr>
<tr>
<td>Trust funds</td>
<td>Incentives: Rewarding good practice</td>
</tr>
</tbody>
</table>

Example of Pooled (Blended) Funds

Wraparound Milwaukee

CHILD WELFARE
Funds thru Case Rate
(Budget for Institutional Care for CHIPS Children)

JUVENILE JUSTICE
(Funds budgeted for Residential Treatment for Delinquent Youth)

MEDICAID CAPITATION
(1557 per month per enrollee)

MENTAL HEALTH
• Crisis Billing
• Block Grant
• HMO Commercial Insurance

Wraparound Milwaukee
Management Service Organization (MSO)
$30M

Per Participant Case Rate

9.5M

8.5M

10M

2.0M

Families United
$300,000

Provider Network
240 Providers
85 Services

Care Coordination

Child and Family Team

Plan of Care

Wraparound Milwaukee. (2002). *What are the pooled funds?* Milwaukee, WI: Milwaukee County Mental Health Division, Child and Adolescent Services Branch.
Example of Braided Funds
DAWN Project - Indianapolis, IN

How Dawn Project is Funded

\[
\begin{align*}
\text{Child Welfare} & \quad \text{Or} \\
\text{Juvenile Justice} & \quad \text{Or} \\
\text{Special Education} & \quad \text{Department of Mental Health}
\end{align*}
\]

\[
\begin{align*}
$4,088 & \quad + \quad $166 & \quad = \quad $4,254 \text{ PMPM}
\end{align*}
\]

Dawn Project Cost Allocation

DAWN Funding – Utilization

- **90%** Direct Services
  - 550 Vendors
- **6%** Indirect Expenses
- **4%** Administrative

RAINBOWS
(Family Organization)
Example of “Virtual” Pooled Funds
Cuyahoga County (Cleveland)

System of Care Oversight Committee

County Administrative Services Organization

Neighborhood Collaboratives & Lead Provider Agency Partnerships

Child and Family Team Plan of Care

Community Providers and Natural Helping Networks

FCFC $$
Fast/ABC $$
Residential Treatment Center $$$$ 
Therapeutic Foster Care $$$
“Unruly”/shelter care $
Tapestry $$
SCY $$

State Early Intervention and Family Preservation
System of Care Grants

Reinvestment of savings

Youth who are at-risk of entering a RTC

Youth referred to a local management entity

Local Management Entity

- Controls the management of treatment services, support services, and housing/placements.
- Money from the three funding sources are streamlined into the local management entity

At risk pool is created for the local management entities

The three sources of funding stream into the local management entity from the state and federal government. The local management entity is held accountable to the state. The three sources of funding are from Medicaid, Mental Hygiene, and a combination of DHR and DJS.

- Medicaid Federal and State (MHS Match)
- Mental Hygiene Block Money
- DHR and DJS

Example of Redirecting Funds
State of Maryland

<table>
<thead>
<tr>
<th>Treatment services</th>
<th>Support services</th>
<th>Housing/Placement services</th>
</tr>
</thead>
<tbody>
<tr>
<td>(in patient (treatment facility) and out-patient (in-home) services)</td>
<td>(respite, behavioral supports, nutrition, etc.)</td>
<td>(foster care, group home, adoption, etc.)</td>
</tr>
</tbody>
</table>

Adapted from State of Maryland, 2004
Parent Support Network of Rhode Island
Diversified Funding Sources & Approaches

**Administrative Infrastructure (4.0 FTE)**
- Executive Director, Assistant Director, Administrative Assistant, and Data and Technology Specialist

**Peer Mentor Program (3.25 FTE)**
- Information & Referral
- Child & Family Teams
- Education Planning
- Support Groups/ Youth Speaking Out Training

**Family & Youth Leadership Program (2.50 FTE)**
- System Reform Training & TA
- Placement on Policy Boards
- Focus Groups
- Social Marketing/ Presentations

**CONLAN (2007). Parent Support Network of Rhode Island Infrastructure and Primary Funding Sources.**
Family Involvement Center Contracts (Maricopa County, AZ)

✓ Contract with ADHS/BHS (State MH)
✓ BHO “administrative functions” contract
✓ BHO contract as provider in network
✓ Contract with State child welfare agency

Financed initially by State legislative appropriation; now financed by:

• State general revenue (MH)
• Tobacco settlement
• Federal MH block grant
• Federal discretionary grant
• Medicaid billable services
• Child welfare (GR and IV-E waiver)

### Examples of Medicaid Options States Use to Cover Evidence-Based and Promising Community-Based Practices (1)

<table>
<thead>
<tr>
<th>Medicaid Option</th>
<th>Advantages</th>
<th>Issues</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehabilitation Services Option</td>
<td>• Flexibility to cover a broad array of services and supports provided in different settings (e.g., home, school)</td>
<td>• Service definitions often adult-oriented • Federal scrutiny</td>
<td>• Many states</td>
</tr>
<tr>
<td>Managed Care Demos and Waivers - 1115 and 1915 (b)</td>
<td>• Accountability and management of cost through risk structuring/sharing • Flexibility to cover wide range of services and populations</td>
<td>• Managed care not without risks/challenges • Federal waiver process can be challenging • Cost neutrality issues</td>
<td>• AZ – covering family peer support, therapeutic foster care</td>
</tr>
<tr>
<td>Home and Community-Based Waivers - 1915 (c)</td>
<td>• Flexibility, broader coverage, waiver of income limits and comparability</td>
<td>• Alternative to hospital-level of care but PRTF (i.e., residential tx.) may be issue • Cost and management concerns so limited to small number</td>
<td>• KS, NY, VT, IN, WI – have HCBS Waivers • AK, FL, GA, IN, KN, MD, MS, MT, SC, VA – have community alternatives to psychiatric residential treatment facilities demonstration grant</td>
</tr>
</tbody>
</table>

### Examples of Medicaid Options States Use to Cover Evidence-Based and Promising Community-Based Practices (2)

<table>
<thead>
<tr>
<th>Medicaid Option</th>
<th>Advantages</th>
<th>Issues</th>
<th>Example</th>
</tr>
</thead>
</table>
| Early and Periodic Screening, Diagnosis and Treatment - EPSDT | • Broadest entitlement  
• Supports holistic (PH and BH) assessments and services  
• No waiver or state plan amendment requirements | • Management mechanism critical because of cost concerns  
• Oriented more to physical health in practice | • PA  
• CA  
• MA |
| Targeted Case Management                              | • Can be targeted to high need populations  
• Supports small case load focus (e.g., 1-10) | • Not sufficient without other services  
• Federal attention | • VT  
• NY |
| Administrative Case Management                        | • Ability to cover basic case management services to support enrollment, access | • Not sufficient without other services | • NJ – covering some activities of family-run organization |
## Medicaid Options

### Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)

- **Advantages**: Avenue to eligibility to community-based services for children who meet SSI disability criteria – allows disregard of family income
- **Issues**: SSI criteria not easy to meet for children with SED
- **Example**: MN, WI

<table>
<thead>
<tr>
<th>Medicaid Option</th>
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<th>Issues</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)</td>
<td>• Avenue to eligibility to community-based services for children who meet SSI disability criteria – allows disregard of family income</td>
<td>• SSI criteria not easy to meet for children with SED • Does not expand types of covered services • Cost issues, so generally small program</td>
<td>• MN • WI</td>
</tr>
<tr>
<td>Medicaid as Part of a Blended or Braided Funding Approach (without a waiver)</td>
<td>• Holistic, integrated (across systems) financing, supports broad array of services, natural supports and individualized care</td>
<td>• Involves significant restructuring</td>
<td>• Milwaukee Wraparound • DAWN Project • Massachusetts Mental Health Services Program for Youth • New Jersey Partnership</td>
</tr>
</tbody>
</table>

Bottom Line

State Medicaid agencies are cobbling together a variety of Medicaid options in attempt to cover and contain community-based services for children - often without involvement of other child-serving systems.

What is needed is a more integrated, strategic financing approach across child-serving systems.

Strategic Financing Analysis

1) Identify state and local agencies that spend dollars on children’s behavioral health services/supports
   - how much each agency is spending
   - types of dollars being spent (e.g., federal, state, local, tribal, non-governmental).

2) Identify resources that are untapped or under-utilized (e.g., Medicaid).

3) Identify utilization patterns and expenditures associated with high costs/poor outcomes, and strategies for re-direction.

4) Identify disparities and disproportionality in access to services/supports, and strategies to address.

5) Identify the funding structures that will best support the system design (e.g., blended or braided funding; risk-based financing; purchasing collaboratives).

6) Identify short and long term financing strategies (e.g., Federal revenue maximization; re-direction from restrictive levels of care; waiver; performance incentives; legislative proposal; taxpayer referendum, etc.).

Creating “Win-Win” Scenarios

Child Welfare
Alternative to out-of-home care
high costs/poor outcomes

Medicaid
Alternative to IP/ER-high cost

System of Care

Juvenile Justice
Alternative to detention-high cost/poor outcomes

Special Education
Alternative to out-of-school placements – high cost

If you have answered the questions:

Financing For Whom?
Financing for What?

I.E.,

 ✓ Identified your population(s) of focus
 ✓ Agreed on underlying values and intended outcomes
 ✓ Identified services/supports and practice model to achieve outcomes
 ✓ Identified how services/supports will be organized
   (so that all key stakeholders can draw the system design)
 ✓ Identified the administrative/system infrastructure needed to support
   the delivery system
 ✓ Costed out your system of care

Then You Are Ready To Talk About Financing!

Characteristics of Effective Provider Networks

- Responsive to the population that is the focus of the system of care.
- Encompass both clinical treatment service providers and natural, social support resources, such as mentors and respite workers.
- Include both traditional and non traditional, indigenous providers.
- Include culturally and linguistically diverse providers.
- Include families and youth as providers of services and supports.
- Are flexible, structured in a way that allows for additions/deletions.
- Are accountable, structured to serve the system of care.
- Have a commitment to evidence-based and promising practices.
- Encompass choice for families and youth.

Examples of Incentives to Providers

• Decent rates
• Flexibility and control
• Timely reimbursements
• Back up support for difficult administrative and clinical challenges
• Access to training and staff development
• Capacity building grants
• Less paperwork

What Natural Helpers and Social Supports Can Provide

• Emotional support; moral & spiritual guidance
• System navigation
• Concrete help & advocacy
• Decrease social isolation
• Community navigation
• Resource acquisition & education
• Greater understanding of intervention or support strategies
• Time Banks

Natural Helpers are...
• Family and friends
• Neighbors
• Volunteers
• Individuals in the community, e.g. mail carrier, minister, storekeeper, etc.
• People with similar experiences
• Faith-based organizations

Pre-Equipo Network

(Color Key: Participants are green, personal network members are yellow, provider from outside Abriendo Puertas is blue diamond)
Post –EQUIPO Network

(Color Key: participants are green, Madrinas are red, participant’s personal supports are yellow, Abriendo Puertas providers are blue, outside providers are cyan)
Rhode Island Time Bank Initiative

- Time Bank Coordinator
- Local Natural Support Network Consultants
- Community Outreach
- Exchanges
- Special Projects
- Database
- Website

Time Bank Core Values: Assets-Redefining Work-Reciprocity-Community-Respect

Conlan (2007). Parent Support Network of Rhode Island Infrastructure and Primary Funding Sources.
Purchasing/Contracting Options

Pre-Approved Provider Lists:
+ Flexibility for system of care
+ Choice for families
- Could disadvantage small indigenous providers
- Could create overload on some providers

Risk-Based Contracts
+ Flexibility for providers
+ Individualized care for families
- Potential for under-service
- Potential for overpaying for services

Fixed Price/Service Contracts
+ Predictability and stability for providers
- Inflexible - families have to “fit” what is available

Capitation and Case Rate Distinctions

**Capitation:** Pays MCOs or providers a fixed rate per *eligible* user

Incentive:

#1: Prevent eligible users from becoming actual users (e.g., make it difficult to access services; engage in prevention)

#2: Control the type and volume of services used

**Case Rate:** Pays MCOs or providers a fixed rate per *actual* user

Incentive:

#1: Control the type and volume of services used
Risk-Based Contracting Arrangement

State-Capped Out of Home Placement Allocation

County DHS acts as MCO (contracting, monitoring, utilization review)

- Child Welfare $$
  Case rate contract with CPA

- BH Tx $$ matched by Medicaid.
  Capitation contract with BHO
  with risk-adjusted rates for child welfare-involved children

Joint treatment planning approved by DHS

Child Placement Agencies (CPA)

- Responsible for full range of Child Welfare Services & ASFA (Adoption and Safe Families ACT) related outcomes

Mental Health Assessment and Service Agency (BHO)

- Responsible (at risk) for full range of MH treatment services & clinical outcomes & ASO functions

Progression of Risk by Contracting Arrangement

<table>
<thead>
<tr>
<th>TYPE OF CONTRACTING ARRANGEMENT</th>
<th>RISK TO SYSTEM OF CARE</th>
<th>RISK TO PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Grant</td>
<td>HIGHEST RISK</td>
<td>LOWEST RISK</td>
</tr>
<tr>
<td>• Fee-for-Service</td>
<td>LOWEST RISK</td>
<td>HIGHEST RISK</td>
</tr>
<tr>
<td>• Case Rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Capitation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Service Coordination/Care Management Structure Principles

• Support a **unitary** (i.e., across agencies) care management/coordination approach even though multiple systems are involved, just as the care planning structure needs to support development of one care plan.

• Support the goals of **continuity and coordination** of care across multiple services and systems over time.

• Encompass **families and youth as partners** in the process of managing/coordinating care.

• Incorporate the **strengths of families and youth**, including the **natural and social support networks** on which families rely.

Goal: One plan of care; one care manager

Children/youth in out-of-home placements

Result: Multiple plans of care; multiple care managers

Definition of Terms

*Service Coordinator*
Assists families and youth with basic to intermediate needs to coordinate services and supports, usually has other responsibilities and/or is assisting large numbers of families and youth.

*Care Manager*
Primary job is to be the accountable care manager for families with serious and complex needs; works with small number of families (e.g., 8-10), has authority to convene child and family team as needed and often has control over resources.
Service Coordination/Care Management Continuum

Children/youth needing only brief short-term services and supports

Information and referral help

Children/youth needing intermediate level of services and supports

Service coordination

Children/youth needing intensive and extended level of services and supports

Intensive care management

Wicomico County, MD
System of Care Structure (Under Development)

LMB
SOC Community Advisory Board

Family Partner-Ship Center

211 System (screening)

Service Coordination/Systems Navigation - CANS

Care Management Unit Care Coordinators Family Partners

Families and Youth

Agencies/Court

Adapted from Wicomico County, MD
Examples of Types of Care Coordinators

- Re-assigned case workers
- Paraprofessional care managers
- Clinical care managers
- Family members as care coordinators
Utilization Management (UM) Concerns

- Who is using services?
- What services are being used?
- How much service is being used?
- What is the cost of the services being used?
- What effect are the services having on those using them? (i.e., are clinical/functional outcomes improving? Are families and youth satisfied?)

Principles for Utilization Management (UM)

- UM must be understood and embraced by all key stakeholders
- UM must concern itself with both the cost and quality of care
- The UM structure needs to be tied to the quality improvement structure
Shared Utilization Management Structures Among Care Managers and Child and Family Teams

- Care plans build in action dates or events for review
- Care plans have scheduled review dates
- Care plans require regular “report backs” from providers
- Families and youth provide review of services
- Family and youth voice drives monitoring and reviews

NJ Children’s System of Care Initiative

Screening with Uniform Protocols

CHILD
- Child Welfare
- JJC Court

Other
School Referral
Community Agencies
Family & Self

Contracted Systems Administrator CSA
- Registration
- Screening for self-referrals
- Tracking
- Assessment of Level of Care Needed
- Care Coordination
- Authorization of Services

CMO
- Complex Multi-System Children
- ISP Developed
- Full Plan of Care Authorized

FSO
Family to Family Support

Community Agencies
- Uncomplicated Care
- Service Authorized
- Service Delivered

2005 State of NJ
Example of Statewide Quality Improvement Initiative

**Michigan**: Uses data on child/family outcomes (CAFAS) to:

- Focus on quality statewide and by locality
- Identify effective local programs and practices
- Identify types of youth served and practices associated with good outcomes (and practices associated with poor outcomes)
- Inform use of evidence based practices (e.g., CBT for depression)
- Support providers with training informed by data
- Inform performance-based contracting

**QI Initiative designed and implemented as a partnership among State, University and Family Organization**

Ex: Contra Costa County’s CQI Structure
Utilizing Data to Drive Quality

- Developing activities to ensure CQI for:
  - Youth with multiple placements
  - Transition-aged youth
  - Multi-jurisdiction youth
  - Youth at-risk for multiple placements

- Developing and Tracking Quality and outcome measures:
  1. E. reduction in number of youth with 3 or more placements;
     linkage to needed resources upon emancipation

Purposes of Utilization and Quality Management/Data: Examples

- Planning and Decision Support (Day-to-Day and Retrospectively)
- Quality Improvement
- Cost Monitoring
- Research
- Marketing
- Accountability

Evaluation & Data Gathering

To eliminate disparities, disproportionalities, and improve access, quality of care, and outcomes we need to identify, collect, analyze, interpret, disseminate, and use both quantitative and qualitative data.

- Questionnaires
- Surveys
- Interviews
- Focus groups
- Clinical outcome data
- Participatory evaluations
- Network analyses
- Financial analyses

"There is a profound difference between information and meaning."

Quote: Warren Bennis, Leadership Institute, University of Southern California
OUTCOMES (Milwaukee Wraparound)

• Reduction in placement disruption rate from 65% to 30%
• School attendance for child welfare-involved children improved from 71% days attended to 86% days attended
• 60% reduction in recidivism rates for delinquent youth from one year prior to enrollment to one year post enrollment
• Decrease in average daily RTC population from 375 to 50
• Reduction in psychiatric inpatient days from 5,000 days to less than 200 days per year
• Average monthly cost of $4,200 (compared to $7,200 for RTC, $6,000 for juvenile detention, $18,000 for psychiatric hospitalization)
Family/Caregiver Experience Wraparound Milwaukee

*Nearly half had previous CPS referral

91% felt they and their child were treated with respect (n=191)

- Very Much So 91%
- Somewhat 5%
- Not At All 4%

72% felt there was an adequate crisis/safety plan in place (n=172)

- Very Much So 91%
- Somewhat 13%
- Not At All 15%

91% felt staff were sensitive to their cultural, ethnic and religious needs (n=189)

- Very Much So 91%
- Somewhat 5%
- Not At All 4%

64% reported Wrap Milwaukee empowered them to handle challenging situations in the future (n=188)

- Very Much So 64%
- Somewhat 29%
- Not At All 7%

Marion Co., IN Outcomes

- Reduced recidivism (youth are 78% less likely to return to a child-serving agency)

- Improved scores on CAFAS, CBCL, BERS

- Improved school attendance and academic performance

- 86% of families reported that services were helpful

- 82% of youth reported that services were helpful

- 86% of families reported that services reflected their family’s strengths and culture
Outcomes (Monroe County Youth and Family Partnership – Rochester, NY)

• Year One cost savings of $3,189 pmpm - $38,274 annual
• Year Two cost savings of $3,813 pmpm - $45,751 annual
• Year One CAFAS score improvements for 69% of youth
• Year Two CAFAS score improvements for 71% of youth

Nebraska Region Three Outcomes

• At enrollment, 35.8% of children were in group or residential care
• At disenrollment, 5.4% were in group or residential care

• At enrollment, 2.3% of children were living in psychiatric hospitals
• At disenrollment, no children were living in psychiatric hospitals

• At enrollment, 7% of youth were in juvenile detention or corrections
• At disenrollment, no youth were in detention or corrections

• At enrollment, 41.4% of children were living in the community
• At disenrollment, 87.1% of children were living in the community

• Improvement in CAFAS scores

• Generation of $900,000 in cost savings
System of Care Functions Requiring Structure

- Planning
- Decision Making and Oversight at the Policy Level
- System Management
- Benefit Design/Service Array
- Evidence-Based Practice
- Outreach and Referral
- System Entry/Access
- Screening, Assessment, and Evaluation
- Decision Making and Oversight at the Service Delivery Level
  - Care Planning
  - Care Authorization
  - Care Monitoring and Review
- Care Management or Care Coordination
- Crisis Management at the Service Delivery and Systems Levels
- Utilization Management
- Family Involvement, Support, and Development at all Levels
- Youth Involvement, Support, and Development

- Staffing Structure
- Staff Involvement, Support, and Development
- Orientation and Training of Key Stakeholders
- External and Internal Communication
- Provider Network
- Protecting Privacy
- Ensuring Rights
- Transportation
- Financing
- Purchasing/Contracting
- Provider Payment Rates
- Revenue Generation and Reinvestment
- Billing and Claims Processing
- Information Management
- Quality Improvement
- Evaluation
- System Exit
- Technical Assistance and Consultation
- Cultural Competence

Human Resource Development Functions

• Assessment of workforce requirements (i.e., what skills are needed, what types of staff, how many staff) in the context of systems change
• Recruitment, retention, staff distribution
• Education and training (pre-service and in-service)
• Standards and licensure
• Credentialing for family and youth providers

Roles for a Full Time Youth Coordinator

• Coordinate the movement
• Coach
• Raise awareness of the importance of youth voice at all levels of the system of care
• Build bridges between the youth and professional worlds
• Foster a youth-guided system and youth-driven movement
• Reconnect youth with the community
• Educate adults and professionals on the importance of youth involvement

Adapted from System of Care- Start Up Webinar Series 2006-2007
# A Developmental Training Curriculum

<table>
<thead>
<tr>
<th></th>
<th>TRADITIONAL</th>
<th>MODIFIED</th>
<th>INTEGRATED</th>
<th>UNIFIED</th>
</tr>
</thead>
<tbody>
<tr>
<td>SYSTEM</td>
<td>State systems develop training along specialty guild lines – Promotion of stronger specialty focus</td>
<td>State systems independently adopt similar philosophy, promoting Collaboration</td>
<td>State systems begin sharing training calendars</td>
<td>State systems pool training staff, merge training events</td>
</tr>
<tr>
<td>PROGRAM</td>
<td>Community agencies and universities operate in isolation</td>
<td>Community agencies and Universities begin joint research and evaluation</td>
<td>Community agencies and universities begin to integrate field staff/families into pre-service training</td>
<td>Community agencies and universities collaborate with larger community, e.g. families as co-instructors; curricula reflect practice goals</td>
</tr>
<tr>
<td></td>
<td>Disciplines train in isolation from one another</td>
<td>Pre-service training remains separate from the field</td>
<td>Student field placements cross agency boundaries</td>
<td>Training geared to system goals</td>
</tr>
<tr>
<td></td>
<td>Instruction is didactic, “expert” No support for cross-training</td>
<td></td>
<td>Cross-agency training gains support</td>
<td></td>
</tr>
</tbody>
</table>

### A Developmental Training Curriculum (continued)

<table>
<thead>
<tr>
<th></th>
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<th>INTEGRATED</th>
<th>UNIFIED</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PRACTICE</strong></td>
<td>Participation in professional conferences on individual basis within agency boundaries</td>
<td>Staff receive training that promotes collaboration, but receive it within agency boundaries</td>
<td>Service teaming is promoted through cross-agency training</td>
<td>Service teams with full family inclusion are the norm</td>
</tr>
<tr>
<td></td>
<td>Services are provided within agency boundaries</td>
<td>Specialty focus predominant</td>
<td></td>
<td>Redefined specialty practice roles develop to support professional identity while promoting collaboration</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Services remain within agency boundaries</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Examples of Cross-System Training

St. Mary’s County, MD and Clark County, NV
Training CPS investigators, permanency staff, mental health clinicians, probation staff, providers, families in a strengths-based, culturally competent, individualized, child and family team approach

State of North Carolina
System of Care Child and Family Team Curriculum and Training Workgroup with goal of developing a consistent practice model to support system of care

Examples of State-Wide Capacity Building Infrastructure

Maryland Innovations Institute

California Institute of Mental Health

Ohio Center for Innovative Practices
Example: Communication Mechanisms in the State of North Carolina

- Meeting calendar
- Website
- Regional meetings
- Brochures

Local Collaborative Communication Committee

### Technical Assistance Taxonomy

<table>
<thead>
<tr>
<th>Technical Assistance</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Consultation</strong></td>
<td>providing advice and opinions</td>
</tr>
<tr>
<td><strong>Coaching or Mentoring</strong></td>
<td>acting as a “trusted guide”, providing direction, prompting, instruction and support</td>
</tr>
<tr>
<td><strong>Facilitation</strong></td>
<td>providing support to a system building process to make the process run more smoothly</td>
</tr>
<tr>
<td><strong>Persuasion</strong></td>
<td>acting as a “provocateur” or “national expert” when systems are stuck or when local system builders cannot carry the message themselves (sometimes simply because it is difficult to be “a prophet in your own land”)</td>
</tr>
<tr>
<td><strong>Training</strong></td>
<td>teaching and skill building</td>
</tr>
<tr>
<td><strong>Peer Support</strong></td>
<td>support provided by someone who has had similar experience</td>
</tr>
</tbody>
</table>
Critical Steps in a System-Building Process

- Identify your population(s) of focus.
- Agree on underlying values and intended outcomes.
- Identify services/supports and practice model to achieve outcomes.
- Identify how services/supports will be organized (so that all key stakeholders can draw the system design).
- Identify the administrative/system infrastructure needed to support the delivery system, including the structure for family/youth partnership.
- Cost out the system of care.
- Develop a strategic financing plan.
Common Elements of Re-Structured Systems

- Values-based systems/family and youth partnership
- Identified population of focus, costs associated with population, funders
- Locus of accountability (and risk) for population of focus
- Single pathway to services for population of focus
- Strengths-based, individualized service planning; care monitoring (e.g., wraparound approach)
- Intensive care management/service coordination
- Flexible financing and contracting arrangements (e.g., case rates, qualified provider panel – fee-for-service)
- Combined funding from multiple funders (e.g., Medicaid, child welfare, mental health, juvenile justice, education)

(continued)
Common Elements of Re-Structured Systems (continued)

- Broad provider network: sufficient types of services and supports (including natural helpers)
- Real time data across systems to support clinical decision-making, utilization management, quality improvement
- Outcomes tracking – child/family level, systems level
- Utilization and quality management
- Mobile crisis capacity
- Judiciary buy-in
- Re-engineered residential treatment centers
- Shared governance/liability
- Training and technical assistance

“The world that we have made as a result of the level of thinking we have done thus far creates problems that we cannot solve at the same level at which we created them.”

A. Einstein