

**PROMISING APPROACHES FOR BEHAVIORAL HEALTH SERVICES
TO CHILDREN AND ADOLESCENTS AND THEIR FAMILIES
IN MANAGED CARE SYSTEMS**

#2: A VIEW FROM THE CHILD WELFARE SYSTEM

Jan McCarthy and Charlotte McCullough

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Research and Training Center for Children's Mental Health
Department of Child and Family Studies
Louis de la Parte Florida Mental Health Institute
University of South Florida
Tampa, FL

Human Service Collaborative
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Document Available From:

Georgetown University Center for Child and Human Development
3307 M Street, NW, Suite 401, Washington DC 20007
202/687-5000 voice 202/687-1954 fax
Attention: Mary Moreland
deaconm@georgetown.edu
Soon to be available on the web at gucdc.georgetown.edu

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Jan McCarthy
Charlotte McCullough

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The Health Care Reform Tracking Project (HCRTP)¹

Since 1995, the Health Care Reform Tracking Project (HCRTP) has been tracking publicly financed managed care initiatives and their impact on children with mental health and substance abuse (i.e. behavioral health) disorders and their families. The HCRTP's *Promising Approaches Series* highlights strategies, approaches and features within publicly financed managed care systems that hold promise for effective service delivery for children and adolescents with behavioral health treatment needs and their families, particularly for children with serious and complex disorders. The *Series* draws on the findings of the HCRTP to date, highlighting relevant issues and approaches to addressing them, that have surfaced through the HCRTP's all-state surveys and in-depth impact analyses in a smaller sample of 18 states.²

The *Promising Approaches Series* is comprised of a number of thematic issue papers, each addressing a specific aspect of managed care systems affecting children with behavioral health disorders. The papers are intended as technical assistance resources for states and communities as they refine their managed care systems to better serve children and families. The following topics are being addressed in the *Promising Approaches Series*:

- managed care design and financing
- services for children with serious and complex behavioral health care needs
- accountability and quality assurance in managed care systems
- the child welfare system perspective
- making interagency initiatives work for children and families in the child welfare system
- clinical decision making mechanisms
- care management
- family involvement.

Methodology of the HCRTP

Many of the strategies and approaches that are described in the *Promising Approaches Series* were identified by key state and local informants who

responded to the HCRTP's all-state surveys and who were interviewed during site visits to 18 states for the HCRTP's impact analyses. Some approaches were identified through other studies and by experts in the field. Once promising approaches and features were identified through these methods, members of the HCRTP team, including researchers, family members and practitioners, engaged in a number of additional methods to gather more information about identified strategies. Site visits were conducted in some cases during which targeted interviews were held with key stakeholders, such as system purchasers and managers, managed care organization representatives, providers, family members and other child-serving agency representatives. In other cases, telephone interviews were held with key state and local officials and family members to learn more about promising strategies. Supporting documentation was gathered and reviewed to supplement the data gathered through site visits and phone interviews.

The *Promising Approaches Series* intentionally avoids using the term, "model approaches". The strategies, approaches and features of managed care systems described in the *Series* are perceived by a diverse cross-section of key stakeholders to support effective service delivery for children with behavioral health disorders and their families; however, the HCRTP has not formally evaluated these approaches. In addition, none of these approaches or strategies is without problems and challenges, and each would require adaptation in new settings to take into account individual state and local circumstances. Also, a given state or locality

¹ The HCRTP is co-funded by the National Institute on Disability and Rehabilitation Research in the U.S. Department of Education and the Substance Abuse and Mental Health Services Administration in the U.S. Department of Health and Human Services. Supplemental funding has been provided by the Administration for Children and Families of the U.S. Department of Health and Human Services, the David and Lucile Packard Foundation, and the Center for Health Care Strategies, Inc. to incorporate a special analysis related to children and families involved in the child welfare system.

² The HCRTP is being conducted jointly by the Research and Training Center for Children's Mental Health at the University of South Florida, the Human Service Collaborative of Washington, D.C. and the National Technical Assistance Center for Children's Mental Health at the Georgetown University Center for Child and Human Development. For information about available HCRTP reports, see Appendix A.

described in the *Promising Approaches Series* may be implementing an effective strategy or approach in one part of its managed care system and yet be struggling with other aspects of the system.

The *Series* does not describe the universe of promising approaches that are underway in states and localities related to publicly financed managed care systems affecting children with behavioral health disorders and their families. Rather, it provides a snapshot of promising approaches that have been identified through the HCRTP to date. New, innovative approaches are continually surfacing as the public sector continues to experiment with managed care. While each approach or strategy that is described in the *Promising Approaches Series* is instructive in its own right, there also are important commonalities across these strategies and approaches. Each paper of the *Promising Approaches Series* focuses on a different aspect of publicly financed managed care systems.

The Child Welfare Papers

Since 1996, the HCRTP has included a special focus on the effects of managed care on children and families involved in the child welfare system. This paper, *A View from the Child Welfare System*, is intended to assist states and communities interested in strategies for meeting the behavioral health needs of children in the child welfare system, and their families, within **managed care systems**. A companion paper in the *Series* focuses on how the child welfare system is participating in collaborative **interagency initiatives** designed to serve children with serious and complex behavioral health disorders. Entitled *Making Interagency Ini-*

Children and Families Involved in the Child Welfare System

This includes children living in their own homes and receiving services from the child welfare system, as well as children in the foster care system. The “foster care system” refers to children who are in the custody of a county or state child welfare agency or a tribal court and who may live in a foster home, group home, kinship care home, residential treatment center, or other out-of-home placement. It includes children who will return home, as well as those for whom another permanent plan will be made such as guardianship or adoption. For the purposes of this study, families needing post-adoption services also are included.

tatives Work for Children and Families in the Child Welfare System, this companion paper describes approaches for including the child welfare system in planning and implementing interagency initiatives, for addressing child welfare system policies, for sharing resources across systems, and for meeting the behavioral health needs of children and families.

How This Paper Is Organized

This paper presents information to consider when designing public managed care to meet the behavioral health needs of children and families involved with the child welfare system. It also presents examples of promising approaches from four states and communities.

A View from the Child Welfare System

Introduction: Describes the Health Care Reform Tracking Project and its methodology.

Section I: Presents a framework for developing a comprehensive approach to serving children with behavioral health needs and their families in publicly funded managed care systems. The framework includes 15 critical components to consider. The section discusses challenges and considerations **unique to the child welfare system** related to implementing each of the components. A checklist of questions for states and communities to consider follows the discussion of each component.

Section II: Describes examples of promising approaches from four states or communities for making publicly funded managed care work for children and families involved with the child welfare system who need behavioral health services.

Section III: Offers concluding observations and summarizes challenges faced by the four states or communities described in Section II, as well as similar key strategies noted across these four sites.

Special Considerations for Children and Families Involved with the Child Welfare System

This section identifies unique issues to consider when adapting publicly financed managed care to meet the behavioral health needs of children in the child welfare system, and their families. These considerations are organized by a comprehensive framework of 15 components that were framed to address issues that have emanated from previous phases of the Health Care Reform Tracking Project (HCRTTP).

The HCRTTP has demonstrated that many children in the child welfare system obtain behavioral health services through managed care. The following reasons explain why it is important for those who plan and implement managed care to carefully address the needs of children and families in the child welfare system.

- ***The high prevalence of serious and complex behavioral health needs among the children and families served by the child welfare system.***

Children in the child welfare system tend to be extremely vulnerable and are at high risk for health, mental health, and developmental problems. For children placed in foster care, the trauma of separation from their families and the experience of multiple moves within the foster care system itself can

increase their vulnerability and compound their mental health problems. Since the principal funding source for health and behavioral health services for children in the child welfare system is Medicaid, Medicaid managed care directly affects this population of children. In the managed care reforms surveyed by the HCRTTP, there was a 22% increase from 1997/98 to 2000 in those reforms that include children involved with the child welfare system—from 60% to 82%. When children in the child welfare system are included in the managed care plan, it is important to consider the special needs of this relatively small group of children who will require higher than average levels of services and supports.

In addition to the needs of the children, many parents, who experience the multiple stresses that lead to involvement with the child welfare system, also need mental health services and supports, as well as substance abuse services. If their needs are not identified and addressed by the managed care plans, it will be more difficult to ensure safety, permanency, and well-being for their children.

- ***The public system's responsibility for children in the child welfare system.***

All children are dependent on others for their care and well-being, but children in the custody of the state are uniquely dependent upon government agencies. When a court determines that the separation of a child from his/her parents is in the child's best interests because of an imminent risk of serious harm, the public system must ensure that all needs, including physical and behavioral health needs, are properly provided.³ Through the Child and Family Services Review process, the federal government requires that states also provide

CRITICAL COMPONENTS*

- ◆ Collaboration
- ◆ Access
- ◆ Initial Screening and Comprehensive Behavioral Health Assessments
- ◆ Clinical Criteria and Utilization Review Procedures
- ◆ Treatment Planning
- ◆ Service Array
- ◆ Provider Issues
- ◆ Family Focus
- ◆ Cultural Competence
- ◆ Coordination of Care
- ◆ Quality Monitoring and Evaluation
- ◆ Information Technology and Management of Data
- ◆ Funding Strategies
- ◆ Training and Informational Materials
- ◆ Early Childhood Issues

*See Appendix B for definitions of each of these components.

³ Child Welfare League of America: Standards for service for abused and neglected children and their families (1989) CWLA.

services to help parents increase their capacity to care for their children⁴.

- ***The judicial role in decision-making.***

The issue related to the authority of the courts is an important consideration for publicly funded managed care systems. Unlike most other children enrolled in Medicaid behavioral health plans, the courts are actively involved in planning for children in the child welfare system. Judges have the final authority to make decisions about the need for placement of a child, and they are charged with approving plans for a child's care when the child is under protective supervision. This authority might extend to ordering or approving plans for behavioral health treatment services for the child or the child's parents.⁵

- ***Federal mandates and state child welfare reforms demand greater accountability in ensuring safety, permanency, and well-being for children in the child welfare system, and greater linkage with behavioral health plans.*** The Adoption and Safe Families Act (ASFA) of 1997, and parallel child welfare reforms in many states and local communities, have increased the pressure on child welfare agencies to achieve permanency for children more quickly and to be held accountable for better outcomes for children and their families. Through the Child and Family Services Review (CFSR) process, the federal government requires that states demonstrate compliance with a number of safety, permanency, and well-being outcomes as well as system performance measures. One of the seven outcomes relates specifically to whether the children receive adequate services to meet their physical and mental health needs. As mentioned above, one of the major outcomes relates to the state's ability to provide services to help parents increase their capacity to care for their children. The CFSR process reaffirms the need for the child welfare system to forge linkages with other systems of support for families, including behavioral health managed care systems.

Consideration of each of the above factors is essential when children in the child welfare system enroll in a managed care plan. HCRTF findings serve as the basis for many of the special considerations discussed below in each component. These considerations are offered to

assist states and local communities in adapting their managed care plans to meet the behavioral health needs of children and families in the child welfare system. *Information that describes what some states and communities are doing related to the components is written in italics.*

1. Collaboration Considerations

The child welfare, mental health, health, Medicaid, court and school systems, as well as providers, families and other caregivers, share responsibility for meeting the behavioral health needs of children in the child welfare system. A key decision that must be made is whether children in the child welfare system and their families will be included in the managed care plan. If it is determined that these children and their families are to receive behavioral health services under the managed care system, top-level commitment to cross-system planning and implementation is required to ensure that their unique needs will be met. This will require:

Early and Significant Involvement of the Child Welfare System in Planning and Problem-Solving—It is important for the special needs of children in the child welfare system to be addressed in system design, in contracts, in setting rates and rate structures, in the make-up of the provider network, and in developing special provisions to meet their needs. Therefore, child welfare representatives should be encouraged to be significantly involved in both early and ongoing planning. When the plan is implemented, at the child/family level, child welfare workers can function as care managers - tracking and advocating for services,

⁴ In March 2000, regulations went into effect for a new approach to federal oversight of state child welfare programs, known as the Child and Family Services Reviews (CFSR). Overseen by the Children's Bureau of the Administration for Children and Families, the review process consists of statewide self-assessment as well as an on-site review, which is conducted by a team of Federal, state, and peer reviewers. Information gathered is used to examine the states' success in meeting the major goals of child welfare—child safety, permanency and well-being. When states do not achieve “substantial conformity” with the required outcomes, they develop Program Improvement Plans to describe how they will reach substantial conformity.

⁵ Battistelli, Ellen. (1996). Making Managed Health Care Work for Kids in Foster Care: A Guide to Purchasing Services. *Child Welfare League of America*, 13.

and adjusting plans to reflect child and family needs. *Collaboration at the system-level between the Medicaid agency, the MCO and the child welfare system is being done by states in a variety of ways—through co-location of staff, sharing of financial resources, cross-system training, designation of special liaisons, interagency collaborative teams, and interagency agreements.*

Strategies for Engaging the Courts—Given the role of the court in child welfare, it is important for the managed care plan to build effective relationships with court staff, Guardian Ad Litem, and CASA⁶ volunteers who may be working on behalf of children in the child welfare system. Building collaborative relationships enables the court to appropriately use its decision making power to improve access to behavioral health services for children and/their families. *Some states have used court improvement activities as a means of enhancing behavioral health assessments and access to treatment for children in child welfare. (See Section II, Philadelphia, PA as one example.*

DISCUSSION TOPICS – COLLABORATION

- What approaches will be used to gain top-level commitment for the collaboration across child-serving agencies, the courts, the purchaser and the MCO to sustain collaborative efforts?
- How will this top level commitment be evident at all levels in the child-serving agencies?
- What are the strategies for ensuring the active participation of the child welfare system during planning, implementation, and evaluation of the managed care plan?
- What are the mechanisms for ensuring ongoing communication, both formal and informal, between the child welfare system, the MCO and other child-serving agencies?
- What are the problem solving vehicles at both the system and individual child/family levels between the MCO, providers, and the child welfare system?
- What are the mechanisms for periodically assessing the costs and effectiveness of collaborative activities?

- How will representatives from the MCO and network providers be included in the state CFSR process?

2. Access Considerations

When child protective services (CPS) workers become involved with families, they need appropriate information in order to make decisions about child safety and family service needs. The CPS worker must gather information, conduct risks assessments, and attempt to understand the child's and family's strengths and needs, including any evidence of mental health or substance abuse issues that may affect child safety or family stability.

A number of things could occur during initial stages of involvement with the child welfare system. For example, if all children in or at risk of foster care placement are eligible for the managed care plan, and if a child or parent's behavioral health issues are primary factors in jeopardizing child safety and family stability, the CPS worker might want to access immediate crisis intervention or assessment services. This would enable the CPS worker to:

- better understand the mental health and substance abuse issues in the family,
- de-escalate the immediate crisis,
- develop a safety and treatment plan that could be implemented in the home and community, and
- attempt to prevent unnecessary out-of-home placement for the child.

If children in placement are covered by the managed care plan, the CPS worker and the courts might want immediate access to assessment services that could help to:

- determine the appropriate level of care, and

⁶ Court Appointed Special Advocates (CASA)

- identify placement resources that would work collaboratively with the child welfare system to achieve timely reunification or another permanent plan for the child.

Immediate access to behavioral health assessments and services is important not only to provide help for the child's and family's clinical needs but also to possibly prevent the need for placement of the child or, if placement is needed, to ensure that the placement chosen can meet the child's clinical, safety, and permanency needs. With appropriate and immediate access to home and community based therapeutic services, it may be possible to divert many children from placement; and if placement is required, to ensure timely reunification with birth families with appropriate therapeutic and other supports in place.

Throughout the time the child and family are involved with the child welfare system, it will be important to identify and remove access barriers, including consideration of the following provisions:

Streamlined Enrollment—Immediate eligibility and streamlined enrollment procedures, as well as ease of access when moving from acute care to extended care services, are important. *To accommodate access, some states and communities assume that children entering the foster care system are eligible for Medicaid until proven otherwise.*

Immediate Access to Crisis Intervention Services and Accessible Sites—In addition to mobile response capability, it is important for plans to locate assessment and service sites within reasonable geographic distances from family homes, to offer extended hours, and to have 24-hour availability for emergency care. *For example, Arkansas uses roving teams to provide multidisciplinary evaluations for all children who enter state protective custody. The assessments, which occur within 60 days, take place in 16 sites located around the state. This allows for interface with community providers and lessens the problem of having to transport children great distances.*

Expedited Consent—Mechanisms must be in place to address problems associated with obtaining consent from parents, guardians, the child welfare agency, or the court for assessment and treatment services. Any confusion about who is responsible for obtaining consent should be clarified during the planning phase. *The Family Court in Philadelphia created a brochure for parents to explain how they can help ensure that their children receive appropriate health and behavioral health services while in court-ordered placement. The brochure identifies the types of consent forms they may be asked to sign (including consent for mental health evaluation), why these consents are important, and what will be done with the information. The consent forms are discussed and signed during a pre-hearing conference with parents that takes place before each adjudicatory hearing.*

Clear Communication Between Child Welfare Agencies and MCOs Related to Eligibility Issues—Many managed care plans include special provisions for children and families involved with the child welfare system. These provisions, however, will not be triggered without a system to convey eligibility and enrollment information between child welfare agencies and managed care entities. For example, how will the MCO know when an enrolled child enters or leaves the child welfare system, when court orders for behavioral health services have been issued, or when a child changes placement?

Continuous Eligibility—In HCRTP's 2000 *State Survey*, 73% of the reforms indicated that there were certain types of placements in which children in the child welfare or juvenile justice systems would lose eligibility for services from the managed care system, for example, residential treatment facilities, state or county operated public institutions, juvenile detention homes, out-of-state placements, and sometimes when returning home (depending on family income). Child welfare workers, courts, providers, and caregivers need to be aware of this possibility, take it into consideration when making placement decisions, and develop other strategies to access needed care. *Philadelphia has created a "managed care unit" that facilitates access to physical health care for children in foster care. The staff in*

this unit know that certain changes in a child's placement can mean loss of eligibility for the managed care plan. They inform those who are making placement decisions and assist in finding other sources of care when the placement change must occur.

Communication with Caregivers and Providers—

When a child is separated from parents and placed in out-of-home care, kinship caregivers, foster parents, or group care providers may be charged with making certain the child has access to behavioral health services. It is important for the public purchaser, the child welfare agency, and the managed care contractor to define their respective roles in informing the child, the child's family, and any alternate caregivers about the managed care plan, the process for enrollment, and the extent of services that will be available to the child and family. Additional services, such as transportation and respite care for other children in the home, may be needed to support caregivers in accessing behavioral health services.

Accessing Services at Transition Points—During the time children and their families are involved with the child welfare system, their living arrangements and service needs will often change. As the managed care plan is being developed it is important to note the transitory nature of child welfare placements and the need to ensure access to services particularly during times of transition—including initial placement, change in placement, reunification or adoption. In addition, some children in foster care “age out” of the child welfare system without having a permanent placement. The child welfare agency and the managed care plan need to consider how these youth who exit the child welfare system (and perhaps lose eligibility for a child-specific managed care reform, but have continuing behavioral health needs) will transition to the adult behavioral health system.

DISCUSSION TOPICS – ACCESS

- Who will determine which children involved with the child welfare system will be included and excluded from the managed care plan ?

- How will it be determined which special provisions might be included to ensure that these children have streamlined eligibility and enrollment?
- Are there provisions for presumptive eligibility for Medicaid?
- What will be the system for enrolling children in the managed care system?
- Who is responsible for the initial referral and for monitoring time it takes for children and families to access needed services?
- Who will be responsible for obtaining consent for assessment and treatment services?
- Are there mechanisms to ensure that consent is obtained in a timely manner when the child first becomes involved with the child welfare system?
- What kind of immediate interventions will be available to the child and family?
- What outreach activities and print materials will be developed to inform parents, caregivers and other child welfare providers about the managed care plan and how they can access care?
- Who will be responsible for helping families—birth, kin, foster and adoptive families—to navigate the managed care system?
- What are the strategies for ensuring communication between the child welfare system and the MCO regarding issues affecting eligibility? For example, who will be responsible for informing the MCO when a child changes placement after initial enrollment?
- How will the plan ensure continuous eligibility for children when placements change?
- How will children aging out of child welfare who have continuing behavioral health needs access the adult services they need?
- How will the plan monitor access by children in the child welfare system?
- What problem-solving mechanisms will be used to address access barriers that are identified?

3. Initial Screening and Comprehensive Behavioral Health Assessment Considerations

Some state child welfare agencies have policies and procedures in place to ensure that children who receive child protective services or are in the foster care system receive an initial health and behavioral health screen within a specified time period. Some states provide comprehensive behavioral health assessments for all children as they enter foster care. In the ideal, these assessments are then used by the child welfare worker, the family, and other members of the treatment planning team to develop an individualized service plan that addresses child safety, permanency, and well-being issues, including issues related to behavioral health needs. The courts often rely upon the assessments to make informed decisions that will affect the child and family in profound ways.

Despite the importance of comprehensive behavioral health assessments, child welfare agencies frequently cite problems in getting assessments completed in a timeframe and manner that is useful in planning for services or guiding court decisions. Issues identified as barriers could be addressed when the child is enrolled in the managed care plan if special considerations are given to the following:

Ensure That Assessment Tools and the People Conducting Assessments Address the Impact of Abuse, Neglect, and Placement—Providers who conduct initial behavioral health screens and comprehensive assessments need to understand the impact of abuse and neglect, be knowledgeable of the life experiences of children in the child welfare system, and place behavioral health findings in the broader context of the trauma a child and family may have experienced. *In some states, clinics that specialize in the screening and assessment of children in the child welfare system provide these services for the MCOs.*

Identification of Parental Behavioral Health Needs—Given the prevalence of behavioral health problems in the parents of children in the child welfare system and the shortened timeframes for making decisions about permanent living arrangements for children, it is

essential that the behavioral health needs of parents are identified during the screening and assessment processes. Strategies for treatment for parents must be created, even if the parents are not “eligible” for services through the child’s managed care plan. *Child welfare agencies in several states and communities have agreed to fund services for parents that cannot be funded through the managed care plan.*

Coordination of Behavioral Health Assessments and Child Welfare Safety and Risk Assessments—Child welfare agencies are responsible for assessing whether a child is, or can be, safe in a particular environment. It is important to coordinate the timing of the mandated risk assessments and behavioral health assessments so that child welfare workers, treatment providers and families have access to the findings of **both** assessments early in the development of child/family service plans. *A number of interagency initiatives that serve children with behavioral health needs incorporate the results of risk assessments in the individualized treatment planning process.*

Systems are needed to:

- identify and refer all children for initial behavioral health screens and, as indicated, comprehensive assessments
- monitor follow-up on recommendations made
- include procedures for re-assessments at transition points in the child’s life—including change in placement, plans for unsupervised visitation, reunification with families, or achievement of another permanency option.

Adequate Funds and Clear Payment Responsibilities—Since multiple systems are involved with children and families in the child welfare system, it is important to clarify who is responsible for conducting and paying for the initial screens and, when indicated, the comprehensive behavioral health assessments. This may be particularly relevant if the court orders certain assessments that would not otherwise be provided. Consideration should be given to adjusting Medicaid eligibility procedures so that children who enter, or are at-risk-of entering, foster care are instantly eligible for

Medicaid-funded initial screens, comprehensive assessments, and any follow-up services that are recommended.

In addition, since the screens and assessments for children and families in the child welfare system may require special expertise and more time, it is particularly important to ensure that reimbursement rates for initial screens and comprehensive assessments are adequate and that there are no built-in disincentives for professionals to identify needs that will result in additional service costs. *Florida requires a very comprehensive behavioral health assessment for all children who enter state custody. In order to ensure that the assessments are comprehensive, providers may bill Medicaid for up to 20 hours per assessment at \$50/hour.*

DISCUSSION TOPICS – SCREENING AND ASSESSMENT

- How will it be determined which children will be screened initially and which children will need and receive a comprehensive behavioral health assessment?
- If screens and assessments for children involved with the child welfare system are not covered by the managed care plan, who will provide and pay for them?
- How will referrals for screening and assessment be handled?
- Who will be charged with collecting medical records and any prior assessments and providing information to the MCO and those responsible for the current assessment?
- Who will be responsible for establishing the timelines for conducting screening and assessments for child welfare populations?
- How will the frequency, the nature, and the responsibility for re-assessments, particularly at transition times in the child's life, be determined?
- How will behavioral health, physical health, child welfare risk and family assessments, and educational assessments be integrated?

- How will the managed care plan ensure that the professionals conducting the assessments are knowledgeable about child welfare and the impact of abuse and neglect on children and their families?
- How will the plan ensure that the screening and assessments are conducted in a child-friendly setting to minimize trauma to the child?
- What role will the child welfare agency have in the selection or adaptation of screening and assessment tools? How will the screening and assessment approaches identify behavioral health needs of family members? Who will provide and pay for needed services for parents if only the child is eligible?
- Who will be responsible for providing and paying for behavioral health screening and assessments ordered by the courts?
- Who will have access to the results of the assessments? How will both the “need to know” and confidentiality be addressed when results are shared?
- Who will be charged with following up on assessments to ensure that recommended services are provided?
- What role will family members or other caregivers have in the assessment process? What information from the assessments will be shared with birth families or other caregivers?
- How will it be determined whether the reimbursement rate for screening and assessment is adequate to compensate providers for the additional time required to conduct assessments for children in the child welfare system and to participate in additional activities such as service plans and testifying at court hearings?

4. Clinical Criteria and Utilization Review Considerations

According to the 2000 HC RTP survey, 63% of public managed care reforms reportedly include clinical decision-making criteria specific to children's behavioral health care. Overall, 62% of these reforms with child-specific criteria reportedly have increased consistency in clinical decision-making. However,

some respondents in earlier site visits noted that medical necessity criteria and review procedures are too narrowly defined to authorize the appropriate type, level, and duration of services for children in the child welfare system.

The child welfare system and managed care both value (perhaps for different reasons) placements and services that are least restrictive and, whenever possible, delivered in the communities where children and families live. Both child welfare and managed care plans share a belief that service decisions should be backed by evidence-based decision support tools that can be used reliably by professionals—thus promoting consistency across the system in how children and families are served. However, if the medical necessity criteria do not allow for consideration of psychosocial, environmental, and safety factors in making clinical decisions, it may be particularly problematic. In the context of the previously described child welfare mandates that relate to safety, permanency, and well-being, e.g., the Child and Family Services Review process, states must be able to demonstrate and document that services were provided to meet the health and behavioral health needs of children and that needed services were provided to parents to enhance their capacity to care for their children.

The special clinical and non-clinical needs of children and families in the child welfare system require consideration of the following issues:

Broad and Flexible Interpretation of Medical Necessity Criteria and Clarity in Payment Responsibility—If medical necessity criteria are used to guide service decisions, the unique factors associated with serving children in the child welfare system and their families should be understood and addressed. For example, it is not uncommon for the child’s clinical needs to improve prior to the time that non-clinical family issues are resolved and reunification or permanency achieved. When this occurs, the managed care plan may determine that the child’s continued stay in a therapeutic setting no longer meets established medical necessity criteria. However, before deciding that the child must be moved, it will be important to

weigh the potential consequences that result from disrupting a stable placement.

Since these children may need continuing care for non-clinical reasons, the managed care plan and the child welfare agency will need to clarify payment responsibility for services or placements that do not meet medical necessity criteria, especially for those mandated by the courts. (*See description of Philadelphia, PA in Section II for approaches to this issue.*)

Consistent Criteria Across Managed Care Organizations (MCOs)—When states/localities using more than one MCO allow each MCO to define and interpret medical necessity criteria, this can cause confusion and inconsistency in care, especially for children in the child welfare system who move from one MCO to another as their placement location or status changes. Using consistent criteria and procedures across MCOs helps to alleviate this problem. *According to the HCRTP 2000 State Survey, several states reported standardized criteria and processes when contracting with multiple MCOs.*

Adaptation of Utilization Review Standards to Fit Child Welfare—In designing authorization and review procedures, it is important for public purchasers and MCOs to recognize that children in child welfare will be more likely to require extended care than most other children. It might be beneficial to adapt the timelines for continuing stay reviews for children involved with the child welfare system. *For example, most children in therapeutic foster care require time to adjust and progress. If utilization reviews occur too frequently or too quickly, it creates unneeded paperwork and threatens placement stability for the child. In a state faced with such restrictions, the MCO and the child welfare agency came to a compromise on the amount of time a child could remain in a therapeutic foster home before the review occurred.*

Taking into Account the Availability of Services—A significant portion of the children in the child welfare system have serious and complex behavioral health needs and may require placement in a hospital or other therapeutic setting while involved with the child welfare system. Clinical criteria are often used to restrict initial admission to, or reduce lengths of stay in,

restrictive settings. While reducing the inappropriate use of restrictive forms of out-of-home care is important, decisions should be made in the context of available, alternative services. When considering the issues of safety and permanency, it is essential that public purchasers and MCOs do not restrict access to any services or placement level in the absence of a full array of home and community-based alternatives.

DISCUSSION TOPICS – CLINICAL CRITERIA AND UTILIZATION REVIEW

- How will child welfare agencies participate in developing:
 - medical necessity criteria
 - level of care criteria
 - prior authorization procedures
 - utilization review procedures?
- What special allowances might be needed for children in the child welfare system?
- How will the clinical criteria and review procedures be standardized across multiple MCOs?
- How will the adequacy and availability of home and community-based services be assessed initially and over time?
- Who will be responsible for providing and paying for court-ordered or other services that do not meet levels of care or medical necessity criteria?
- What mechanisms might be developed to track denials of care for children in the child welfare system?
- What problem-solving mechanisms can be created between child welfare, the MCO, and the purchaser when the criteria or the interpretation of them are brought into question?

5. Treatment Planning Considerations

Both child welfare agencies and behavioral health providers may engage the child and family in a planning process to develop “plans” for services. Child welfare agencies must develop with families a service plan⁷ for children receiving child protection, family preservation, foster care, or adoption services. This plan includes **goals related to safety, permanency, and well-being**. It includes needed health and

behavioral health services for the child and/or parent. The behavioral health provider may also engage the child and family in an examination of child and family behavioral health needs, resulting in a treatment plan⁸ that describes the services and supports that will be provided to reach clinical goals.

Special considerations related to treatment and service planning children in the child welfare system highlight the need for:

Coordination Between Behavioral Health And Child Welfare Planning Processes and Resulting Plans—It is important for child welfare agencies and publicly funded managed care systems to consider ways that the child welfare and behavioral health planning processes and the resulting plans can be coordinated to reduce confusion for the child and family and to ensure that services provided by both systems support safety, permanency, and the attainment of clinical goals. *Some child welfare agencies have begun to address this issue by the use of family conferencing approaches to service and treatment planning. The end result of family conferences is a comprehensive plan, developed by a team that might include the child welfare worker, behavioral health and child welfare providers, the child’s Guardian Ad Litem, the child, the child’s immediate and extended family, and the child’s current caregiver. The plan integrates the child and family’s behavioral health treatment goals and services into the overall service plan that addresses safety, permanency, and well-being concerns.*

Assessments that Guide Treatment and Service Plans—Children should receive child welfare and behavioral health services that are appropriate to their needs and not simply what is available. If the service and treatment plans are not developed jointly, at a minimum, the child welfare system and the MCO should consider strategies for ensuring that **both** systems have access to relevant assessment information when deciding on the clinical and non-clinical services that will be provided to the child and the family. This

⁷ In this report the term “service” plan refers to the mandated child/family service plan which focuses on a placement goal for the child, is regularly reviewed, and is periodically presented to the court for approval.

⁸ The term “treatment” plan is used to refer to the plan for behavioral health services and treatment.

assessment information should be used to guide the treatment planning process.

Approach to Working with Families—It creates difficulties for families if child welfare and behavioral health providers do not share similar values and approaches toward working with families in developing service plans and treatment plans, e.g., one system telling the family what they are expected to do and the other system asking the family what services they need. It is important for managed care plans and the child welfare system to discuss the approach to service planning that will be used by front line workers and providers.

DISCUSSION TOPICS – TREATMENT PLANNING

- How will the behavioral health treatment and child welfare service planning processes and the resulting treatment and service plans be coordinated?
- How will MCOs/providers and the child welfare system create similar and consistent approaches for involving families in the service and treatment plan process?
- What strategies could be implemented to provide mental health and substance abuse consultation to child welfare workers so they may better understand the child's and family's needs when developing the service plans?
- How will the child welfare assessments related to safety, permanency, and well-being be shared with and used by the MCO to develop treatment plans?
- How will behavioral health assessments be shared with and used by child welfare to develop the service plan (related to safety, permanency, and well-being)?
- What are the mechanisms to ensure that the MCO is aware of any court-orders the child or family may have for services when treatment plans are developed and services authorized?
- What special provisions might be used to ensure that caregivers have the support services needed to participate in the development and implementation of the child's treatment plan?

6. Service Array Considerations

Children involved with the child welfare system and their families have therapeutic and non-therapeutic service needs. In terms of behavioral services, they need access to both acute and extended care. They also need to have their behavioral health services coordinated with non-clinical services to ensure that all interventions are directed towards achieving safety, permanency, and improved well-being.

According to the HC RTP 2000 *State Survey*, most managed care plans do cover both acute and extended care for children. However, other child-serving systems, including child welfare, may also share responsibility and resources for some behavioral health services and for providing a host of non-clinical services and supports. Regardless of who has the responsibility for creating and paying for services, children in the child welfare system and their families require:

A Full Array of Acute and Extended Care Therapeutic Services—While it would be helpful to obtain all of these services through the behavioral health system, essential services used by children in the child welfare system may not be covered by the managed care plan. The child welfare agency and the MCO need to determine how children will access non-covered services and clarify payment responsibilities. It is also important for the child welfare system and the managed care plan to identify any barriers that may jeopardize the ability of a child to move smoothly from one service to another as needs change. This may be particularly important for children who receive some extended care services through the managed care plan and other services through child welfare or other child-serving systems.

In some states, child welfare agencies and MCOs share the cost of extended psychiatric care. For example, Massachusetts has a program in place for transitioning children from intensive psychiatric placements to a lower level of care. The BHO pays for the first 30 days of service in the lower level of care, and the Department of Social Services (DSS) picks up the cost on day 31. This enables a child to move out of an unnecessarily intensive and restrictive psychiatric placement, thus reducing costs, while providing DSS with 30 days to arrange payment in

the lower level of care, or to determine if the child is ready to move back to the community with support services. While resolving some problems, it has been noted that this plan can mean yet another short-term placement if the child does not stay long in the step-down placement. In Connecticut, the Department of Children and Families (DCF) and the MCO share costs for children in custody who are placed in inpatient psychiatric care. The MCO pays for the first 15 days of care, DCF and the MCO share the cost for the next 45 days, and after 60 days, DCF pays the full cost.

An Ongoing Process to Assess and Address the Adequacy and Availability of Services—It is important that the managed care plan and the child welfare system jointly assess service gaps and develop strategies with other child-serving systems for increasing capacity or adding new services. Gaps could relate to services for a particular subgroup of children, such as adolescents or children with mild to moderate behavioral health needs; the availability of services in both urban and rural areas; and, as previously noted, the availability of home and community-based services and step-down options that can be used as alternatives to restrictive placements or hospitalization.

DISCUSSION TOPICS – SERVICE ARRAY

- How will the child welfare agency participate in the determination of which services will be included in the managed care plan?
- How will children access excluded services? Who will provide them and who will pay for them?
- How will the managed care plan assess the service needs of the children in the child welfare system initially and over time?
- If gaps or duplication in services for children in the child welfare system are identified, who will determine how services will be added, expanded, or streamlined? How will child welfare participate in that process?

7. Provider Considerations

The HCRTTP has explored a range of provider issues that have a direct impact on the delivery of services to children in the child welfare system, including: provider skills, the availability of specialty providers, reimbursement rates, and administrative burdens. The HCRTTP found that child welfare providers (i.e., providers who traditionally have provided family support, foster care, behavioral health, and related services to the child welfare population) are not included in provider networks in 47% of the reforms. If children and families involved with the child welfare system are to be included in the managed care plan, their unique needs should be considered in developing the provider network, including their need for:

Providers With Knowledge and Experience In Working with Children in the Child Welfare System and Their Families

—The exclusion of child welfare providers has both clinical and fiscal implications. If a provider with experience in working with children in the child welfare system is not in the managed care system network, the child welfare agency may have to pay for that provider's services outside the network or choose to use a network provider who may not be as familiar with the child and his/her service needs. It is important for the managed care plan and the child welfare agency to work together to ensure that network providers have the knowledge and skills required to meet not only a child's clinical needs but also to:

- understand and address issues of safety and permanency,
- understand the trauma the child may have experienced,
- accept and work effectively with the child's birth parents and other caregivers, and
- work well with child welfare staff.

For an example, see the description of the Kinship Center in Section II. In California, the Kinship Center, an organization with expertise in serving adoptive families, became a provider for the county managed mental health plan.

Adequate Rates For Providers—The child welfare agency and the managed care plan should work to ensure that there are no disincentives (e.g., lower reimbursement rates or administrative burdens) for child welfare agencies to participate in the MCO network. Since children in the child welfare system may require longer than average services, the MCO also should ensure that there are no penalties for providers if children need extended or specialized services. It is advisable for the MCO and the state to periodically assess the adequacy of reimbursement rates for providers serving children in the child welfare system.

Knowledge and Inclusion of Smaller, Community-Based Agencies—Smaller agencies may have limited infrastructure and few professional staff with credentials to be in a position to participate formally in the MCO network. It is, however, important for the MCO and the child welfare agency to find ways to engage a wide array of community, non-traditional agencies to support children in the child welfare system and their families. Managed care plans might consider using community liaisons, who know how to develop and find needed resources and work with child welfare workers to access appropriate community services and supports.

Inclusion of Specialists—The provider network needs to include specialists who understand the unique needs of children who have been abused or neglected and their families. For example, specialized skills are needed in working with victims and perpetrators of sexual abuse; in addressing separation, loss, and attachment issues in children and families following placement; and in recognizing and addressing issues that may arise pre- and post-adoption, or after reunification with the birth family.

Continuity in Providers—For a variety of reasons, children involved with the child welfare system often experience frequent planned and unplanned placement changes—from county to county, out of state, from one type or level of placement to another, and in and out of their own homes. Sometimes this means moving out of the geographic area covered by their managed care plans. Managed care systems need to be aware of the possibility of frequent moves and develop a plan

both to minimize disruption of care by providers and to follow-up on service needs identified in a child's previous placement.

In California, the Mental Health Director's Association adopted an Intra-County Memorandum of Understanding for Foster Youth in Out-of-Home/Out-of-County Care in 1998. This MOU was developed to facilitate a system of care approach to meeting the mental health needs of children in foster care who reside out-of-county (in a county different from the county where they came into custody). Such a MOU is necessary in California because when children in foster care move to another county, the county of origin is responsible for funding mental health services in the child's new home county. The county mental health plan, the department of social services, and probation (when involved) are expected to collaborate prior to the child's move to determine whether appropriate providers are available in the new county and how the child's behavioral health needs can be met.

DISCUSSION TOPICS – PROVIDER ISSUES

- How will traditional child welfare providers participate in the provider network? How will they be recruited?
- What strategies might be used to include small, community-based, non-traditional providers?
- How will the MCO identify and recruit the types of specialists needed by children in the child welfare system?
- How will the rates and payment structures to providers who will serve children in the child welfare system be determined? How will the sufficiency of rates be assessed?
- What are the mechanisms that could be developed to allow a child to continue with the same provider when he/she moves from one MCO geographic area to another?
- What supports or incentives will be included to encourage behavioral health providers to participate collaboratively in activities such as family conferences, service planning meetings, and court hearings?

- What role will the child welfare agency have in monitoring the quality of care of providers within and outside of the network who serve children and families involved with child welfare?

8. Family Considerations

In the HCRTTP 1999 *Impact Analysis*, child welfare stakeholders emphasized that managed care plans need to take into account the child’s “bigger picture”, i.e., that a child’s involvement with the child welfare system is temporary and that services must address the needs of the family as well as the child. When a child is in the foster care system, it is necessary for the managed care plan to begin first by expanding the definition of “family.”

Special considerations related to families include the following:

Instilling a Family Focus In Treatment Planning—If there are no specific safety issues (or court orders) that prevent birth families from being involved with their children, it is important for the managed care plan to incorporate requirements for birth family involvement at the service delivery level and to specify the services and supports that will be available to allow them to actively participate in treatment planning. Family involvement not only helps to ensure that the child’s behavioral health needs are identified and met, it also helps the family to define services and supports that would enable them to continue or resume parenting responsibilities. Since the vast majority of children in the child welfare system are eventually reunited with birth families or kin, it is critical that they be engaged in planning for that eventuality.

Clarifying Who Is Considered “Family”—Children involved with the child welfare system may have several “families.” They may live with or be working towards reunification with their birth parents or other kin. They may currently be living with extended family or foster families. Children who cannot return to their birth families may be placed with adoptive families. It

is important for the child welfare agency and the MCO/provider to have mechanisms in place for communicating the role of the various caregivers in a child’s life and in determining how all of the caregivers will be involved in and/or kept informed about their child’s treatment.

Coordinated Family-focused Interventions—Since both the behavioral health and child welfare agencies may be working separately with the family on different issues, it is important for them to ensure that family-focused interventions are coordinated and intended to reach mutually desirable goals. In addition, it is possible that the child may receive services through one MCO and the family or siblings through another. When this is the case, it is important to consider mechanisms for collaborative work with families between MCOs and between providers.

Services for Parents and Other Family Members—As previously noted, many parents involved with the child welfare system struggle with mental health problems or substance abuse. A 1994 study found that substance abuse was a factor in the placement of 75% of the children entering foster care.⁹ It is critically important for child welfare agencies and managed care plans to find or provide services for parents, even if they are not eligible for Medicaid or a member of the same MCO as their child. *The preservation of families is dependent upon parents receiving appropriate services. Some managed care plans have contracted with providers to offer substance abuse treatment services for families involved with the child welfare system. They have found that when parents participate in substance abuse treatment, children are more likely to remain at home or to return home.*

Ongoing Communication & Specialized Training—It is important to ensure that families are fully informed about their child’s behavioral health needs. Training on behavioral health issues and management techniques should be provided for families—birth, kin, foster, or adoptive families. This is particularly important prior

⁹ United States General Accounting Office. (1994). *Foster Care: Parental drug abuse has alarming impact on young children*. Report No. HEHS-94-89. Washington, DC.

to reunification or adoption to ensure that progress made while the child was in foster care is sustained in the home and community.

Family Involvement at the System Level—Families need to be involved in system planning, in implementation, and evaluation efforts. For children in the child welfare system, it is important to gain the insights of birth, foster, kin and adoptive parents.

Assessing Family Satisfaction—Since children in the child welfare system may be included in several “families” - their birth families, foster parents, extended family members, guardians, and adoptive parents – it is important that satisfaction surveys reach each of the child’s caregivers.

DISCUSSION TOPICS – FAMILY FOCUS

- What contract requirements might ensure that the parents and/or caregivers of children in the child welfare system are given opportunities to participate in planning for their child(ren)?
- What supports might be included to enhance family participation?
- For children in foster care, who will determine how birth and foster families will be involved?
- When it has been determined (by the child welfare agency or the court) that contact between the child and birth family members is not appropriate, what are the mechanisms to ensure that the MCO has that information?
 - In those cases, who is responsible for keeping the birth family informed about the treatment plans?
 - When the situation changes and birth family contact is encouraged, how will the MCO be informed?
- What are the mechanisms to ensure that the focus of interventions is on the entire family and not just the identified child?
- When a child is served by one MCO and the family is served by another MCO, what are the mechanisms for collaborative planning and service coordination between MCOs?

- If behavioral health services for parents are not included, how will family members access those services and who will pay for them?
- What are the requirements in contracts that support family involvement at the system level, and what are the special provisions for including families involved with the child welfare system? (For example, will there be family-to-family support strategies, advocacy, or support organizations specifically for families involved with the child welfare system that are supported by the managed care plan?)

9. Cultural Competence Considerations

While 64% of the respondents to the 2000 *State Survey* indicated that requirements for cultural competence under the managed care system were stronger than in the previous system, respondents in the 1997 and 1999 site visits indicated that despite including cultural competence requirements, managed care reforms have had little, if any, effect on the overall level of cultural competence of managed care systems. Considering the factors identified below, the lack of adequate attention to and impact on cultural competence in managed care has a particularly significant impact on the child welfare system.

Disproportionate Representation of Children of Color in the Child Welfare System—A number of studies have shown that for numerous reasons, children of color, particularly African-American children, are over-represented in the child welfare system. African American children come into foster care at greater rates, remain in care longer¹⁰, and are more likely to be served in out-of-home placements than are Caucasian children.¹¹

¹⁰ Greenblatt, Sarah. (1997). The Adoption and Safe Families Act of 1997: A Quick Look and Implications for Practice. *Permanency Planning Today*,3(2).

¹¹ Tom Morton. (1998). National Study of Protective, Preventative and Reunification Services Delivered to Children and Their Families. Atlanta: Child Welfare Institute.

Culturally Competent Managed Care Systems Can Help—Culturally competent managed care systems can provide the opportunity to lessen the problem of disproportionate representation by:

- promoting early identification of children in need of mental health services
- providing services tailored to each child’s cultural context
- offering culturally appropriate services to parents affected by mental illness or substance abuse
- initiating mental health and substance abuse services in communities that have historically under-served people of color.¹²

Valuing Culturally Competence At The System Level—It is important for the managed care plan to actively recruit diverse providers, ensure training on the importance of culturally competent practice, offer linguistically and culturally appropriate services to all enrolled children and their families, and report progress in meeting standards for cultural competence to the public purchaser.

Track Service Utilization Or Outcomes By Culturally Diverse Groups—Few managed care reforms currently track outcomes by diverse groups. The child welfare agency, the purchaser, and the MCO all have a responsibility to ensure that evaluation and ongoing monitoring identifies any disparity in access to services or outcomes for children of color or from diverse cultural and linguistic backgrounds. It is important for them to develop mechanisms for responding to any evidence of bias.

DISCUSSION TOPICS – CULTURAL COMPETENCE

- How will cultural issues be considered in designing, implementing, and evaluating the managed care plan? How will cultural issues specifically related to children in the child welfare system be addressed?
- What are the mechanisms to ensure that screening, assessment tools and clinical criteria are free of cultural or racial biases that could jeopardize quality of care?
- How does the MCO ensure that providers who conduct behavioral health assessments are knowledgeable about the impact of linguistic and cultural patterns on assessment results?
- How will the MCO and providers demonstrate prior experience and skill in working with diverse populations, including those in the child welfare system?
- What training on culturally competent practice will be provided for MCOs and providers, specifically addressing the issues related to child welfare?
- What is the approach for recruiting an adequate number of culturally diverse and linguistically competent staff and providers?
- How will the child welfare system or MCO track the behavioral health utilization, outcomes, and costs of serving racially and culturally diverse children and families?

10. Coordination of Care Considerations

Children in the child welfare system and their families receive services from multiple systems and multiple care managers. For this reason, it is extremely important to coordinate the care they receive. The critical coordination issues described below relate to: coordination of health and behavioral

¹² J. McCarthy, J., Meyers, J., and Jackson, V. (1999). *The Adoption and Safe Families Act: Exploring the Opportunity for Collaboration Between Child Mental Health and Child Welfare System*. Washington, DC: Georgetown University Child Development Center and Washington Business Group on Health, 27.

health care; coordination between the child welfare worker and the behavioral health care manager; and continuity at transition points for children within the child welfare system.

Coordination Between Health And Behavioral Health Care—Many children in the child welfare system experience poor health; inadequate previous medical care; incomplete, non-existent or “lost” medical records due to frequent moves and multiple placements; and a lack of coordination between physical health and behavioral health services. Enrollment in a managed care system offers some opportunity for improving current practice through better initial gathering of information and ongoing mechanisms for coordination between the MCO and other health and child-serving systems.

It is important to clarify which agency has the primary responsibility for obtaining medical records and histories and confidentiality releases, and then forwarding appropriate information to all parties serving the child and family at the time the child is referred for behavioral health services, as well as each time the child experiences a move. The MCO should have an organized method for documenting, storing, updating, and sharing health and behavioral health care information among the various agencies that are providing services to the child—including the MCO, child welfare agency, foster and birth parents, the providers—ideally through a health passport or shared computerized information system. *While many states and communities have developed health passports to track a child’s medical care, fewer are including information about behavioral health care in the passport.*

Coordination Between the Child Welfare Worker and the MCO/Provider Care Managers—Care coordination and case management for children in the child welfare system have historically been the responsibility of public or private child welfare workers. However, when the child is enrolled in a managed care plan, the MCO also has responsibility for managing and coordinating behavioral health services. These overlapping responsibilities between the child welfare system and the MCO can create problems in delineating primary responsibility and accountability.

Since a fundamental purpose in both systems is to coordinate the provision of services to individual children and families, it is important for the MCO and the child welfare agency to clearly define the care management duties of each system in order to reduce duplication and confusion. *Many states have used cross-training and ongoing problem-solving mechanisms to address this.*

Care Coordination During Times of Transition—To further complicate the challenges in coordination, children in the child welfare system experience many transitions - both in moving from one placement to another while in foster care, and when they achieve permanency through reunification, adoption, independence, or guardianship. For a variety of reasons—including high child welfare staff turnover and changing MCO provider networks—they may also experience several different workers or care managers during their involvement with the child welfare system. Each time a worker changes or a child moves, he or she is faced with building new relationships. There also is a risk that vital information may be lost, that follow-up to recommendations may not occur, and that new relationships will have to be created with MCOs and providers. It is important for the MCO and the child welfare agency to anticipate and respond to these transitions and challenges, to minimize disruptions to the child, and to ensure continuity of care for the child and family in each new placement.

DISCUSSION TOPICS – COORDINATION OF CARE

- How will physical and behavioral health care services be coordinated?
- How will mental health and substance abuse services be coordinated?
- How will primary care providers, behavioral health providers, and child welfare workers communicate with each other and with the child’s parents and caregivers?
- What are the provisions to ensure that health and behavioral health information on a child is shared from the time of initial enrollment until the child exits the child welfare system? How will health

and behavioral health care information follow the child who may experience frequent moves?

- What are the mechanisms for coordinating the work of MCO coordinators with child welfare workers and other child-serving systems?
- What are the strategies for care coordination during predictable and unpredictable times of transitions for children in the child welfare system and when child welfare workers or behavioral health care managers change?
- How will the reimbursement rates for care coordination/case management activities be determined?
- What authority or input, if any, will child welfare workers have in authorizing and coordinating behavioral health assessments and services?
- What are the mechanisms for resolving differences between the child welfare worker and the MCO regarding services needed by the child and family?

11. Quality Monitoring and Evaluation Considerations

Evaluation of a managed care system often has various components, including assessing whether the system adhered to procedural requirements, whether services provided were appropriate to identified needs, whether children and their families benefited from the services received, whether defined outcomes were achieved, and how customers rate their satisfaction. Plans may also include a range of quality assurance and improvement mechanisms and be subjected to independent evaluations. Despite the desire to develop sound approaches to monitoring and evaluation, the HC RTP has found that many managed care systems struggle to collect and use data to guide services at the individual service level or to use aggregate data to evaluate performance and drive future planning.

When children involved with the child welfare system are included in the managed care plan, it is important to isolate and compare the data related to their care from the data related to all other enrolled children.

Involving child welfare stakeholders in the design of the monitoring and evaluation plan will enhance the likelihood of including child welfare system outcomes and indicators in the plan. Consideration should be given to:

Collection and Use of Data Specifically Related to Children in the Child Welfare System and their Families—Examining data on children and families in the child welfare system confirms whether services are meeting their needs and if they are faring at least as well as other enrolled children and families. At a minimum, data related to service utilization, outcomes, satisfaction, and costs should be tracked and reported on children in the child welfare system and compared with similar data for all enrolled children or pre-defined performance benchmarks. When the child welfare system has contributed funds to the managed care plan, it is especially important to know if this investment is cost-effective and if the intended outcomes are being achieved. *Seventy-four percent (74%) of the managed care reforms in the HC RTP's 2000 State Survey reported that they track the use of behavioral health services by children in the child welfare system. However, only 35% of those reforms that track this information use it for system planning.*

Development of Specific Performance Standards and Monitoring Procedures for Children in the Child Welfare System—If managed care plans are to serve children and adolescents in the child welfare system, they need to examine specific child and family outcomes that look not only at behavioral health issues but also at the safety, permanency, and well-being requirements of the child welfare system. *Some managed care reforms have jointly defined system performance standards and child/family outcomes in ways that do address the specific mandates of the child welfare system.* Data elements particularly relevant to the child welfare system include things such as placement stability and proximity to the child's community and family; child status in key life domains; the restrictiveness of placements; access to community-based services; timeliness of achieving permanency; family satisfaction; and crisis management.

Grievance and Appeals Mechanisms—Together the state, the MCO and the child welfare agency need to decide who can file a grievance or an appeal regarding service denials or quality of care issues on behalf of a child in the child welfare system—the child’s birth parent, the foster parent, and/or the child welfare worker? It is also important for the state and the MCO to track and report actions taken in response to all grievance and appeal processes and decisions for children in the child welfare system. Many states have statutes and laws regarding the use of independent review organizations that should include consideration of any special circumstances relating to children and families in the child welfare system.

Assessing Satisfaction from the Perspective of Child Welfare—Most managed care plans include provisions for periodically assessing satisfaction from a number of perspectives. As was mentioned previously, if children involved with the child welfare system are included in the plan, it is important to assess the satisfaction of parents and any other caregivers of the child. In addition, other child welfare stakeholders—including child welfare workers and administrators, child welfare providers (especially those who have been brought into the network), and the courts—should be surveyed. The results can be used to guide system improvements, specifically for children involved with child welfare.

DISCUSSION TOPICS – QUALITY MONITORING AND EVALUATION

- What is the role of the child welfare agency in the development of initial outcome and system performance measures and in creating grievance and appeals processes?
- What are the responsibilities of the MCO and of the child welfare system in tracking and reporting specific performance measures related to children in the child welfare system?
- How will utilization, outcomes, and costs for children and families in the child welfare system be tracked and reported separately from other enrollees, and who will be responsible for this?
- What other data does the child welfare system need to obtain from the MCO?

- How will data be aggregated for the child welfare population and used for system planning? What will be the child welfare agency’s role in this effort?
- How will grievance and appeals for children in the child welfare system be tracked separately from other children?
- What are the specific mechanisms to ensure that families and caregivers of children in the child welfare systems fully understand grievance and appeals procedures? Who is responsible for transmitting that information?
- What kind of processes need to be created to determine the satisfaction of child welfare stakeholders with the managed care plan? For example, how will child welfare workers and administrators; birth parents, foster parents, and other caregivers; child advocates; and the courts be invited to provide input?

12. Information Technology Considerations

The HC RTP has found that in many managed care reforms, inadequate management information systems are considered to be a major impediment to effective communication of vital information and system accountability. Child welfare agencies attempt to collect a variety of essential information, including relevant health and behavioral health care history, on the child and family at the time the child’s case file is opened. For some states, child and family behavioral health information is stored in the state’s automated child welfare data system. Child welfare data must be periodically reported to federal agencies and used in the previously described Child and Family Services Reviews. However, like managed care systems, automated management information systems used by child welfare agencies have historically been problematic. New technology is being tested in child welfare and in the managed care arena. *Increasingly, web-based systems, with appropriate security safeguards, are being used to facilitate the storing and electronic sharing of information between various agencies and professionals involved with a child and family.*

Adequate Management Information Systems and the Capacity to Share Information Across Systems—

Regardless of the system used, it is important that vital information collected by the child welfare agency is appropriately shared with the MCO at the time the child is enrolled and throughout the time the child is involved with the child welfare system. Similarly, relevant information collected by the MCO and providers must be available to the child welfare agency to document that services were provided to address the child's health and behavioral health needs. A system must be in place to facilitate this sharing of data.

When the managed care plan is being developed it is important for the public purchaser, in collaboration with other child-serving systems, to clearly define the data that will be collected, from which sources, for what purposes, at what frequency and to ensure that the MCO contract holds the contractor accountable for developing the technological capacity to meet data collection and reporting requirements. The child welfare system needs to work with the MCO to create the capacity for the MCO's data system and the child welfare data system to share relevant information. It is important for the MCO to fully understand the health and behavioral health data requirements of the Child and Family Services Review process and to work with the child welfare system on how documentation and reporting will occur.

Mechanisms to Ensure Compliance with Confidentiality Requirements—The Health Insurance Portability and Accountability Act of 1996 (HIPAA) has far reaching implications for children's services systems and any organization that uses technology to manage information related to health care billing or service delivery. The child welfare agency and the MCO will have to ensure compliance with all HIPAA standards. With appropriate safeguards, confidentiality issues should not prohibit the sharing of information.

DISCUSSION TOPICS – INFORMATION TECHNOLOGY AND DATA MANAGEMENT

- How will the health and behavioral health information that the child welfare worker obtains be made available to the MCO?

- How will the MCO's data for children in the child welfare system be shared with child welfare?
- Will both the child welfare and MCO data systems store this information? Will the systems be web-based, allowing for electronic transfer or uploads?
- How will the child welfare agency work with the MCO in meeting reporting requirements of the Adoption and Safe Families Act and ensure that all information required by the CFSR is documented?
- Who will be responsible for quality assurance of the data system to ensure the timeliness, security, and accuracy of data?
- How will confidentiality issues be monitored and handled? What are the mechanisms to ensure compliance with all HIPAA requirements?
- Will penalties and bonuses be included in MCO contract for the accurate and timely collection and reporting of data?

13. Funding Considerations

Multiple funding streams and procedures are involved in providing services for children in the child welfare system including, in many states, publicly financed managed care. Special funding issues to consider include:

Accountability for Shared Funding—In order to maximize resources, it is important for states to consider how funds from various child-serving agencies can be combined within the managed care plan to offer a wide variety of services and supports. The HCRTP *2000 State Survey* found that 21% of the managed care reforms included funds from the child welfare system. When child welfare funds are contributed to the managed care plan, it is necessary to define how those funds are to be used and to periodically report actual expenditures. The child welfare system must be guaranteed that it will not lose money. If child welfare funds are contributed, then the children and services that were covered by those funds prior to being moved to the managed care plan must be covered within the managed care plan.

If behavioral health funds are given to the child welfare agency to provide services excluded from the managed

care plan, it is important to define how those funds will be tracked and reported. Interagency agreements can be used to clarify how funds will be transferred and used. *Many state and community interagency initiatives, designed to meet the behavioral health needs of children from multiple systems, have successfully blended or braided funds from different child-serving agencies and created systems to track the use of these funds.*

Adequate Reimbursement Rates—A major factor affecting the likelihood that children and adolescents in foster care will receive the full extent of services they require is the adequacy of the reimbursement for the MCO and for the providers. The state and the managed care plan should periodically assess the adequacy of rates and make adjustments as needed to ensure accessibility to high quality services for children and families in the child welfare system.

Risk Arrangements and Incentives/Penalties—If risk-based arrangements are to be developed for providers who will serve children in the child welfare system, it will be important for the managed care plan to identify and address any potential unintended consequences that could result. For example, providers should not be penalized when a specified number of children exceed a certain level of service. Instead, the MCOs could offer incentives for providers to attain specified outcomes that are developed collaboratively with the child welfare agency. *A few states have developed risk-adjusted rates for children in the child welfare system.*

Identifying and Addressing Cost Shifting—It is important for the managed care plan to have the capacity to track and monitor cost-shifting in a systematic way and to develop mechanisms to prevent it. The HCRTTP found that cost-shifting is less likely to occur in reforms that incorporated strategies to clarify responsibility for providing and paying for services across child-serving systems.

DISCUSSION TOPICS – FUNDING STRATEGIES

- Will the plan include funds from other child-serving systems?

- If funds from multiple sources are used, how will the state and the MCO clarify payment responsibilities across child-serving systems?
- What are the options for transferring and blending funds?
- Once funds have been blended, how will expenditures by funding source be tracked and accounted for?
- How are the costs of providing behavioral health services to children in the child welfare system going to be assessed initially and on an ongoing basis?
- Will there be any special considerations made for the increased costs associated with these children and families?
- What are the options for providing incentives to providers who can demonstrate effectiveness in working with children and families in the child welfare system?
- What are the approaches that could be used to create more flexible use of funds, such as addressing service code, authorization, and encounter reporting barriers between the child welfare system and the purchaser?
- How will the state and the MCO periodically assess the overall adequacy of funds for serving children, especially those in the child welfare system?
- How will decisions be made about whether to limit profits? If profits are to be limited, how will the amount of this limit be set?
- What will be the approach to reinvestment of some profits or savings specifically for children in the child welfare system?
- What are the mechanisms for ensuring that risk-based financing arrangements do not adversely affect access to care, specifically for children in the child welfare system?
- What are the mechanisms for tracking cost-shifting across systems and for resolving the problem?

14. Training Considerations

Child welfare stakeholders in HC RTP site visits cited multiple training needs on the part of MCOs and providers to familiarize them with the service needs of children and families involved with the child welfare system. Child welfare workers and families needed training about the managed care plan. They frequently lacked adequate information about the managed care system to make appropriate decisions and to secure needed services. Many respondents highlighted the need for systematic ways to offer cross-system training.

Training MCOs about the Special Issues Associated with Serving Children in the Child Welfare System—According to the HC RTP 2000 State Survey, more than half of the reforms do train MCOs about the unique needs of children and families involved with the child welfare system. This can significantly enhance the ability of the MCO to serve this population. The child welfare system—including social workers, the courts, caregivers, and families—can contribute in developing the training curricula and/or conducting the training.

Training Child Welfare Audiences about MCO Policies and Operations—It is equally important for the MCO to provide training to enable caregivers and child welfare workers to navigate the managed care system. This is occurring in many managed care systems. Providing supportive services, such as transportation, can increase the likelihood that parents and caregivers can attend training. MCOs can work with the child welfare agency to develop training materials appropriate for child welfare audiences.

Training for Providers—If child welfare providers and practitioners are included in the network, they may need specialized training on new skills and approaches required for success—including short-term treatment and wraparound approaches, family-focused service interventions, cultural competence, home and community-based alternatives. The MCO and the child welfare system should collaborate in the development of this training.

Training for Families—As previously noted, families of all types need specialized training to help them understand and respond appropriately to the behavioral health needs of their children and to recognize their own behavioral health needs.

DISCUSSION TOPICS – TRAINING

- Who will be involved in developing the plan for cross-training between MCOs and child welfare?
- What supports—such as transportation allowances or child care—might be provided to encourage caregivers to attend training?
- What training will be provided to ensure that providers and MCOs have the knowledge and skills to work with children and youth who may have experienced severe and chronic abuse, sexual abuse, and neglect—including skill building in civil and criminal court testimony, conducting extensive court-ordered evaluations, understanding the child’s legal and placement status, communicating with the people who share responsibility for the child?
- What training on evidence-based practices and new interventions will be provided to child welfare providers and practitioners in the network to ensure they have the new skills and approaches required for success—including short-term treatment and wraparound approaches, family-focused service interventions, cultural competence, home and community-based alternatives?
- What training will be provided to families—birth, kin, foster, and adoptive families—to help them understand and manage the care of children with mental health or substance abuse treatment issues?
- What will be the role of the child welfare agency and of families in the child welfare system in developing the training plan or facilitating training?

15. Early Childhood Considerations

Children under the age of five are entering the child welfare system at increased rates. Infants are the largest single-year age group who are victims of abuse and neglect. Thirty-eight percent (38%) of the children who entered foster care in FY1998 were under

the age of five.¹³ Given this reality, it is critical for the behavioral health system to offer a range of services that are appropriate for meeting the mental health and developmental needs of young children, including being able to identify their unique needs and respond through services that are developmentally appropriate.

Ability To Identify And Meet The Behavioral Health Needs Of Young Children—The first challenge is to identify mental health needs in very young children. It is important for the professionals who are completing the initial behavioral health screens and comprehensive assessments, to be sensitive to the developmental and unique needs of very young children and to understand the impact of abuse or neglect on child development. The assessment tools must be developmentally appropriate. *Some states and communities are using Medicaid’s Early and Periodic Screening, Diagnosis and Treatment program as the funding source for comprehensive developmental and mental health assessments for young children involved with the child welfare system. For an example of a community’s effort to provide and fund developmental services for young children, see the description of the Seedling Project (a program of the Kinship Center) in Section II.*

Adequate Services for Young Children—The most recent HC RTP survey indicates that 56% of all reforms provide “few” or no services to the early childhood population. If the very young children in the child welfare system are included in the managed care plan, the MCO should work with the child welfare system and other early childhood providers to better define and build capacity to meet their mental health and developmental needs.

Coordination with Existing Service Systems for Young Children—Young children (from birth through age two) with disabilities or delays are eligible for early intervention services and supports under Part C of the Individuals with Disabilities Education Act (IDEA). If enrolled in Medicaid, they are also entitled to the full array of EPSDT services. Managed care plans need to be knowledgeable about the early intervention resources provided through Part C and to have links to the early intervention systems in their communities so that young children with developmental problems and their families will be referred to the system of services available through Part C of IDEA.

DISCUSSION TOPICS – EARLY CHILDHOOD

- Given their unique and complex needs, how will it be determined whether young children should be included in the managed care plan or served outside the plan?
- If they are covered, how will children in need of a developmental screen be identified? What will be done to ensure that the current behavioral health screens and assessments appropriate to identify needs in very young children?
- How will the plan assess whether there are adequate types of in-home and community-based services for young children who may have many developmental and mental health needs in addition to histories of abuse or neglect?
- How will the plan identify and recruit providers knowledgeable about early childhood issues?
- How will behavioral health services be coordinated with other early childhood providers, including IDEA, Part C and EPSDT?
- What early childhood funding sources can be included in to the plan?
- What are the options for providing consultation specific to early childhood issues to caregivers and professionals that interact with the child everyday—child welfare workers, the pre-schools, day care providers, families, caregivers?

16. Using the Framework of Comprehensive Components

All of the components discussed in this section would be evident in an *ideal* managed care system. They have been presented and discussed here, not as a prescription for how all managed care systems should work, but rather as important issues for public purchasers and managed care entities to consider when designing or refining a comprehensive managed care approach to address the behavioral health needs of children and families involved with the child welfare system. To be consistent in format and to carry the theme of a comprehensive framework into real life examples, we use these components as the organizing framework for describing the four site examples in the following section.

¹³ *Child Welfare Outcomes 1998: Annual Report*. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children’s Bureau, A-2 and A-6.

Description of Promising Approaches

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

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

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

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

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

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

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

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

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

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

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

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

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

PHILADELPHIA, PENNSYLVANIA

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

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

OVERVIEW OF THE PENNSYLVANIA BEHAVIORAL HEALTH SYSTEM

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

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

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

OVERVIEW OF THE PHILADELPHIA BEHAVIORAL HEALTH SYSTEM

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

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

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

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

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

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

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

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

COLLABORATION

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

Weekly BHS/DHS Integration Meetings

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

Behavioral Health and Wellness Support Center (the Center)

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

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

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

²⁰ Forkey, Mental Health Services, 13.

²¹ 0Forkey, Mental Health Services, 12.

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

SECTION 2

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

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

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

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

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

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

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

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

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

Collaboration with Family Court

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

- Pre-Hearing Conferences
- BHS Family Court Unit.

Pre-Hearing Conferences

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

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

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

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

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

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

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

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

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

BHS Family Court Unit

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

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

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

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

ACCESS

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

Automatic Enrollment

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

Help Desk

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

Authorization

No prior authorization is required for outpatient services.

Written Guides

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

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

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

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

Out-of-Network Providers

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

COORDINATION OF CARE

Care Management Responsibility

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

Integrating Behavioral Services and the Family Service Plan

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

CLINICAL CRITERIA

Increased Clinical Expertise

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

EXPANDING THE SERVICE ARRAY

Confronting the Challenges

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

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

FUNDING STRATEGIES

Determining Payment Responsibility

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

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

Funding the Behavioral Health and Wellness Center

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

KEY COLLABORATIVE STRATEGIES

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

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

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

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

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

REMAINING CHALLENGES

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

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

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

ADVICE

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

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

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

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

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

²⁶ Forkey, Mental Health Services, 5.

SECTION 2

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

FOR FURTHER INFORMATION CONTACT:

Dr. Joseph Kuna
Behavioral Health and Wellness Support Center
Philadelphia Department of Human Services
1515 Arch St.
Philadelphia, PA 19102
215/683-6018
Joseph.E.Kuna@phila.gov

Alba Martinez
Commissioner
Philadelphia Department of Human Services
1515 Arch St.
Philadelphia, PA 19102
Alba.E.Martinez@phila.gov

Nancy Lucas
CEO
Behavioral Health Services
714 Market St.
Philadelphia, PA
215/413-7102
Nancy.Lucas@phila.gov

KINSHIP CENTER[®], MONTEREY COUNTY, CALIFORNIA

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

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

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

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

KINSHIP CENTER

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

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

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

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

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

COLLABORATION

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

The Adoption Clinic - How It Evolved

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

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

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

The Seedling Project - How It Evolved

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

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

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

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

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

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

FUNDING STRATEGIES

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

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

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

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

ACCESS

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

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

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

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

DEVELOPING THE SERVICE ARRAY

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

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

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

Developmental services provided through the Seedling Project include:

- in-home developmental screening (English and Spanish)

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

PROVIDER NETWORK ISSUES

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

FAMILY PARTICIPATION

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

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

CULTURAL COMPETENCE

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

MONITORING AND EVALUATION

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

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

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

EARLY CHILDHOOD ISSUES

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

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

KEY FEATURES

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

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

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

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

REMAINING CHALLENGES

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

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

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

FOR FURTHER INFORMATION CONTACT:

Carol Biddle
Executive Director
Kinship Center
124 River Road
Salinas, CA 93908
Phone: (831) 649-3033*
Fax: (831) 649-4843*
cbiddle@kinshipcenter.org
1-800-4-KINSHIP (toll free in CA)
www.kinshipcenter.org

* (NOTE: Kinship Center is moving its headquarters to the above address on 3/15/03. The phone number listed here will change at that time.)

Deborah Silverstein
Associate Director
1504 Brookhollow Drive, #111
Santa Ana, CA 92705
Phone: (714) 957-1004
Fax: (714) 957-1065
dsilverstein@kinshipcenter.org

Special Kids ♥ Special Care

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

INTRODUCTION

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

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

Special Kids ♥ Special Care

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

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

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

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

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

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

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

COLLABORATION

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

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

FUNDING STRATEGIES

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

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

SCREENING AND ASSESSMENT

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

COORDINATION OF CARE

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

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

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

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

PROVIDER NETWORK

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

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

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

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

MONITORING AND EVALUATION

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

KEY FEATURES

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

SECTION 2

- **Access to a specialized network of providers**—The nurse practitioners can access specialty providers both through the NHP network and through providers outside of the network, when needed.
- **Collegial and collaborative relationships**—Building positive relationships among the contracting agency (DMA), the referring agency (DSS), and the managed care organization (NHP) has been one of the strong points of the program. There is a shared desire to help each other in making this work for children and families.
- **Continuity of care at transition times**—When a child is reunified with his/her own family or placed in an adoptive home, the nurse practitioners work with the birth or adoptive parents to help them understand the child's health care needs and to provide the information they will need to address all of the child's health care needs. If a child will be using different providers when no longer enrolled in SK/SC, the nurses help make the transition to the new providers.
- **24/7 on-call coverage by clinicians familiar with every child**—The SK/SC pediatric nurse practitioners provide 24/7 coverage for symptom management, management of ER visits and support for the foster parents.

CHALLENGES

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

- **Engaging multiple families in the care of one child**—For the children in foster care who are involved with their birth families, the nurse practitioners have had to learn how to work with birth and foster parents simultaneously. They have learned how to address visitation, coordination of care, and training in the child's specific health care needs from the perspective of both the foster and birth parents. Nurse practitioners often teach two families, and sometimes two or more social workers (DSS, contract foster care agency worker, child's mentor) about the child's health care needs.

FOR FURTHER INFORMATION CONTACT:

Ruth Ikler
Manager of Disability Policy for the Office of Acute and Ambulatory Care
Division of Medical Assistance
600 Washington St.
Boston, MA 02111
Phone: (617) 210-5464
RIkler@nt.dma.state.ma.us

Priscilla Meriot, R.N., MS
Executive Director, Community Medical Alliance
Neighborhood Health Plan
253 Summer Street
Boston, MA 02210
Phone: 1-888-897-8947
Priscilla_Meriot@nhp.org

Mary Lutz, R.N., MPH
Director
Medical Services Unit
Department of Social Services
24 Farnsworth Street
Boston, MA 02210
Phone: (617) 748-2358
Mary.Lutz@state.ma.us

ASSESSMENT AND CONSULTATION TEAM RIVERSIDE COUNTY, CALIFORNIA³⁴

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

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

ASSESSMENT AND CONSULTATION TEAM (ACT)

The ACT program was designed to:

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

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

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

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

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

COLLABORATION

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

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

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

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

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

FUNDING STRATEGIES

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

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

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

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

ACCESS

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

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

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

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

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

PROVIDER ISSUES

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

FAMILY FOCUS

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

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

KEY FEATURES

- **Co-location**—Working together in the same office is essential to making it work. When social workers and clinicians are housed in the same office, it improves attitudes and encourages informal conversations and information sharing. Social workers become more sophisticated about mental health issues, and clinicians understand the realities of the child welfare system and the families served. It provides the opportunity to offer mental health support to the social workers themselves.
- **Interagency relationships**—There is dedication on the part of both DMH and DPSS to make this work. They are willing to work through problems together. Support comes from top-level administrators from both agencies.
- **Clinical expertise**—The ACT program has brought clinical expertise to DPSS. The search for appropriate providers is in the hands of a mental health expert. Social workers and foster parents do not have to spend their time searching (often through the phone book) for treatment providers. Mental health care has become continuous, social workers are not responsible for reauthorizing care, and they no longer fear that children will slip through the cracks.
- **Important qualities**—Essential qualities for the ACT clinician are: knowledge of the community and its resources, thorough understanding of the county mental health managed care plan, strong communication skills, organizational skills, the willingness and ability to respond quickly and to consult with social workers as a colleague, rather than as an expert.
- **Access to services for other family members**—Even if they are not eligible for Medi-Cal and the county's managed care plan, parents and other family members must be able to access services. DPSS assumes this responsibility in Riverside County.
- **Services can be obtained promptly**—Children who are not in an emergency situation will be seen within two weeks. If a provider is not able to see them within that time frame, another provider is sought.
- **Creation of a strong provider network**—A community-based provider network supplements and expands the range of services available through the county mental health clinics. This fills what had been a gap in services - community-based care for children with moderate mental health needs. Providers must have the expertise to meet the special needs of children/families served by the child welfare system, and also the variety of cultures residing in the county.
- **Fiscal savings for DPSS**—The ability to bill Medi-Cal for services previously paid for by DPSS creates a fiscal savings for DPSS.

REMAINING CHALLENGES

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

- Court related issues—It remains a challenge to justify plans and recommendations to the court, where they may be overridden. Some judges are supportive of appropriate mental health treatment, some may order it inappropriately, and others rarely order it.
- Families—There are very few vehicles for families to provide input related to the ACT program. The system also needs policies about the role of families in their children’s mental health care. (This exists in county clinics, but is less clear in individual providers’ practice.) Family expertise is needed to pinpoint needed resources at the individual and system levels.
- While respondents noted the many benefits of ACT, it has been difficult to actually prove that the ACT program is cost effective and produces better outcomes for children and families.
- Recruiting and retaining ACT clinicians continues to be a challenge. Many clinicians want to provide more hands on treatment and direct services.
- Clerical support is central to the program’s effectiveness.
- Provide clinicians with time to do some ongoing direct services also. This helps with retention. The ACT program uses DPSS funds for this, since the federal funding source used for clinician salaries does not allow for provision of ongoing direct services.
- It is easy to be seduced by the “paper”, e.g., if a provider provides good reports, but this does not necessarily mean s/he provides good treatment and vice versa.
- Training around mental health issues is important for social services staff.
- Provide mental health clinicians for social workers to deal with stress of their work.
- Be sure the provider network has an adequate number of providers of color and female providers, especially for girls who have been sexually abused.

ADVICE

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

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

FOR FURTHER INFORMATION, CONTACT:

Debbie LeFevre
 Riverside County Department of Mental Health
 9707 Magnolia Avenue, 2nd FL
 Riverside, CA 92503-3609
 Phone: (909) 358-6898
 Fax: (909) 687-5819
dlefevre@co.riverside.ca.us

Donna Dahl
 Children’s Services Manager
 Riverside County Department of Mental Health
 9707 Magnolia Avenue
 Riverside, CA 92503-3609
 Phone: (909) 358-4520
DDAHL@co.riverside.ca.us

Concluding Observations

REMAINING CHALLENGES

Despite the phenomenal progress made by the sites, they continue to face challenges:

Service Capacity and Provider Network—Even with structures in place to coordinate care, to communicate across systems, and to involve families in service planning, several of the sites believe that they do not have sufficient service capacity to meet the needs of children and families in the child welfare system. They continue to seek new providers and to encourage old providers to “retool” the way they do business, but waiting lists for services still exist. It continues to be difficult to find appropriate providers in rural areas and providers who are familiar with the diversity of cultures represented in the child welfare system.

Involvement of Families at the System Level—Respondents from several sites recognized that families are the ones with the expertise to pinpoint needed resources and to make recommendations about policy change, but most had not created a structure or a systematic way to reach out to families from the child welfare system and to request their input.

Role Clarification—Even with strong collaboration during the planning phases, when a care coordinator takes on responsibilities that have traditionally belonged to front-line social workers, the process of “letting go” is difficult for some social workers.

Measuring Change and Outcomes—Several of the sites noted the need for “proof” of their effectiveness and wished that they had additional resources for more comprehensive program and outcome evaluations.

Serving Children Who Are Not Eligible for Medicaid—Because Medicaid is the primary funding source for most of these initiatives, it has been a challenge to develop strategies for serving children who are not eligible for Medicaid.

KEY STRATEGIES

The sites described in this paper have creatively developed unique strategies for making their efforts work in their own states and communities. However, several sites noted similar key strategies.

Collaborative Relationships—All of the sites described long-term collaborative relationships among systems that have sustained their efforts. Trust, respect, persistence, and dedication were words used to describe the relationships among child welfare, mental health, and the Medicaid agency in most of the sites. They expressed a sharing of core beliefs and a willingness to work through problems together. In all of these sites there is top-level commitment from the child welfare, mental health and Medicaid systems to make the initiative work.

Communication Systems—Along with collaborative relationships, strategies to ensure ongoing communication were noted. Some sites specified primary liaisons between systems; and in two sites, care coordinators ensured that families, providers, and systems communicated on a regular basis. Child welfare service plans that addressed safety, permanency and well-being were integrated with health and behavioral health plans through the care coordinators. Clinical review team meetings and interagency administrative staff meetings were common forms of communication.

Funding Strategies—Each of the four sites figured out funding strategies that enabled them to implement the initiative. Medicaid was a major source of funding in each of the sites, but the child welfare agency also contributed funds, space, and staff resources. Foundation funds and tobacco settlement funds also played a part.

In addition to tapping into a variety of funding sources, specific funding strategies were put into place, for example:

- In one site the child welfare agency and the behavioral health organization realized that they needed to coordinate in setting provider rates so that they would not be competing with each other for providers.
- The Massachusetts Medicaid agency has established a limited no-risk capitated payment arrangement with its contracted managed care organization which is intended to meet the contractor's service costs for each child enrolled in the Pilot program, Special Kids ♥ Special Care.
- When the child welfare agency (DPSS) in Riverside County was able to leverage federal Medicaid funds to pay for the ACT clinicians and to reimburse providers for services, the agency was able to reduce its local expenditures. However, DPSS also agreed to reimburse the Department of Mental Health for all costs for services that were not reimbursed by Medi-Cal, to use DPSS funds to enable ACT clinicians to do some direct clinical work, and to fund services (not reimbursable through Medi-Cal) for family members of children in care.
- To create the Adoption Clinic in California, the child welfare agency contributed start-up costs, and the county managed mental health plan contracted with the Kinship Center for ongoing services. When neither of these agencies could fund needed expansion, the Kinship Center applied for and received funds from the Children and Families Commission.
- Most of these sites indicated that decisions about services were driven by the needs of the child and family, not by which agency was responsible for payment.

Increasing the Clinical Expertise of the Child Welfare Agency—Three of the four sites felt that due to the initiative, the clinical expertise of social workers in the child welfare agency increased significantly. Ongoing consultation with clinicians, advice from care coordinators, and review team meetings were three contributing strategies.

Government Entities and a Non-Profit Serving as MCO/BHOs—In three of the four sites, the county or city operated the managed care organization for behavioral health services. One of the sites described this as the child welfare agency and the BHO “being on the same side”. The non-profit health plan that manages the pilot in Massachusetts has many years experience serving Medicaid consumers and operating a care coordination model. Two of the sites described willingness on the part of the MCO/BHO to access providers outside of the established network when needed for a child and family's individual needs.

Families—While only one of the sites described active involvement of family members in planning and implementing the initiative, they all described the child and family's need for services as the rationale for decisions made. The first priority is to determine what services are needed and which providers to use. Determining payment responsibility follows. This attitude was expressed by child welfare, Medicaid and behavioral health respondents.

Appendix A

Reports Published by the Health Care Reform Tracking Project

Appendix B

Comprehensive Framework for Serving Children with Behavioral Health Needs and Their Families in Publicly Funded Managed Care Systems: Critical Components

APPENDIX A

Reports Published by the Health Care Reform Tracking Project

All reports of the HC RTP are available from the Research and Training Center for Children's Mental Health, University of South Florida (813) 974-6271:

Stroul, B. A., Pires, S. A., & Armstrong, M. I. (2001). *Health care reform tracking project: Tracking state health care reforms as they affect children and adolescents with behavioral health disorders and their families—2000 state survey*. Tampa, FL: Research and Training Center for Children's Mental Health, Department of Child and Family Studies, Division of State and Local Support, Louis de la Parte Florida Mental Health Institute, University of South Florida. (FMHI Publication #198)

Pires, S. A., Stroul, B. A., & Armstrong, M. I. (2000). *Health care reform tracking project: Tracking state health care reforms as they affect children and adolescents with behavioral health disorders and their families—1999 impact analysis*. Tampa, FL: Research and Training Center for Children's Mental Health, Department of Child and Family Studies, Division of State and Local Support, Louis de la Parte Florida Mental Health Institute, University of South Florida. (FMHI Publication #183)

Pires, S. A., Armstrong, M. I., & Stroul, B. A. (1999). *Health care reform tracking project: Tracking state health care reforms as they affect children and adolescents with behavioral health disorders and their families—1997/98 state survey*. Tampa, FL: Research and Training Center for Children's Mental Health, Department of Child and Family Studies, Division of State and Local Support, Louis de la Parte Florida Mental Health Institute, University of South Florida. (FMHI Publication #175)

Stroul, B. A., Pires, S. A., & Armstrong, M. I. (1998). *Health care reform tracking project: Tracking state health care reforms as they affect children and adolescents with behavioral health disorders and their families—1997 impact analysis*. Tampa, FL: Research and Training Center for Children's Mental Health, Department of

Child and Family Studies, Division of State and Local Support, Louis de la Parte Florida Mental Health Institute, University of South Florida. (FMHI Publication #213)

Pires, S. A., Stroul, B. A., Roebuck, L., Friedman, R. M., & Chambers, K. L. (1996). *Health care reform tracking project: Tracking state health care reforms as they affect children and adolescents with behavioral health disorders and their families—1995 state survey*. Tampa, FL: Research and Training Center for Children's Mental Health, Department of Child and Family Studies, Division of State and Local Support, Louis de la Parte Florida Mental Health Institute, University of South Florida. (FMHI Publication #212)

The following special analyses related to the child welfare population are available from the National Technical Assistance Center for Children's Mental Health, Georgetown University (202) 687-5000:

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

Schulzinger, R., McCarthy, J., Meyers, J., Irvine, M., and Vincent, P. (1999). *Health care reform tracking project: Tracking state health care reforms as they affect children and adolescents with behavioral health disorders and their families—Special Analysis Child Welfare Managed Care Reform Initiatives—the 1997/98 State Survey*. Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center.

APPENDIX B

A Comprehensive Framework for Serving Children with Behavioral Health Needs and Their Families in Publicly Funded Managed Care Systems: Critical Components

INTRODUCTION

Before considering the unique challenges in meeting the behavioral health needs of children in the child welfare system in publicly managed care plans, it is important first to consider what it takes to meet the behavioral health needs of **any** child and family in a managed care environment. A number of important issues emanated from earlier phases of the Health Care Reform Tracking Project and from other studies conducted by the Georgetown University Center for Child and Human Development.³⁶ The 15 components described below were framed to address these issues.

These components would be evident in an *ideal* managed care system. They are presented here, not as a prescription for how all managed care systems should work, but rather as important issues for public purchasers and managed care entities to consider in designing or refining a comprehensive managed care approach to behavioral health care for children, adolescents and their families.

CRITICAL COMPONENTS

- ◆ Collaboration
- ◆ Access
- ◆ Initial Screening and Comprehensive Behavioral Health Assessments
- ◆ Clinical Criteria and Utilization Review Procedures
- ◆ Treatment Planning
- ◆ Service Array
- ◆ Provider Issues
- ◆ Family Focus
- ◆ Cultural Competence
- ◆ Coordination of Care
- ◆ Quality Monitoring and Evaluation
- ◆ Information Technology and Management of Data
- ◆ Funding Strategies
- ◆ Training and Informational Materials
- ◆ Early Childhood Issues

COMPONENT DEFINITIONS

Collaboration

The publicly-funded managed care system is planned in collaboration with other public child-serving systems that will refer children into the system. Representatives from child-serving systems, as well as family representatives, develop ongoing mechanisms to prevent and resolve problems and to monitor progress at both the individual child/family and system levels.

Access

Eligibility, enrollment and authorization processes ensure that children and their families are able to access both basic mental health services and special mental health services without encountering barriers or waiting lists. They can move seamlessly from one service to another and from acute care to extended care as their changing needs dictate. Services are geographically and linguistically accessible, as well as culturally and clinically appropriate.

Initial Screening and Comprehensive Behavioral Health Assessments

Consistent with Early and Periodic Screening, Diagnosis, and Treatment (EPSDT—a federally mandated Medicaid service) guidelines, an initial screen is provided to all children as they enroll in a managed care plan to identify health and behavioral health problems that require immediate attention, and to identify children in need of more comprehensive assessments. When comprehensive assessments are indicated, they address both strengths and needs, and focus on the child, the family, and the environment in which they live. Screenings and assessments are

³⁶ Meeting the Health Care Needs of Children in the Foster Care System, September 2002.

conducted by qualified providers in accessible settings and are appropriate to a child's culture, as well as his/her physical, mental/emotional, and developmental condition.

Clinical Criteria and Utilization Review Procedures

Clinical criteria and review processes are used to ensure consistency in practice, to manage resources, and to attain improved child and family behavioral health outcomes. When appropriately used, clinical criteria and reviews serve as guidelines that do not restrict access to services identified through an individualized assessment and treatment planning process.

Treatment Planning

Behavioral health treatment plans are developed collaboratively with the child/adolescent and family members. Professionals involved in treatment planning are skilled in identifying and working with children with behavioral health needs. The behavioral health treatment plan comprehensively addresses each child and family's strengths and needs.

Service Array

A full array of preventive, acute, and extended care services, including specialty services needed by children and their families, is covered. Services consider each child's family, community, and cultural contexts; are developmentally appropriate and child-specific; and build on strengths. Services take place in settings that are appropriate and natural for the child and family. Traditional and non-traditional approaches to care are offered. Services covered by the plan are available without wait lists or other barriers to access.

Provider Issues

A comprehensive, integrated delivery network (within a single managed care organization or among a group of providers) includes adequate numbers of qualified professionals, with the knowledge, experience, skills and cultural diversity needed to work with children with behavioral health needs and their families. Children can access specialists as their needs dictate.

Family Focus

Families participate as full partners in all stages of the decision-making and treatment planning processes for their child(ren). Family members can access the services they need through family-focused service interventions. At the system level, families are included in planning, implementing, and evaluating the managed care system.

Cultural Competence

Professionals who work with children and families have the skills to recognize and respect the beliefs, behavior, ideas, attitudes, values, customs, and language of diverse cultures. An understanding of the diverse cultures represented by enrolled children influences program development, the provider network, and the overall design and evaluation of the system.

Coordination of Care

Responsibility for the coordination of care for children with serious and complex behavioral health needs is assigned to one person or to a special unit to ensure that health care, behavioral health care, and services from other systems are coordinated.

Quality Monitoring and Evaluation

Monitoring and evaluation efforts ensure that behavioral health care services are being provided to children and their families as they were planned. Improvements are made on the basis of the results of the monitoring system. Performance expectations and child/family functional outcomes are measured.

Information Technology and Management of Data

The managed care entity has the capability to gather, organize, retain, and share a child's behavioral health information in a way that ensures accuracy and confidentiality. Information is available to the family and other appropriate persons involved with the care and treatment of the child. Data related to individual children can be aggregated in order to determine utilization, outcomes, service gaps, and costs. This information is used to guide policy decisions.

Funding Strategies

Public agencies and MCOs understand how to use a variety of funding resources to pay for different behavioral health benefits for children and their families. The costs of the system have been assessed and adequate funds are available to support quality services. Agencies enter into interagency agreements to transfer funds, maximize funding, and increase flexibility.

Training and Informational Materials

Cross-training occurs between the MCO and the child-serving systems to ensure a common understanding of each system's goals and operating procedures. Print materials describing the plan are tailored to different audiences and made available in the languages of the enrolled members. They are widely distributed to parents, child-serving agencies, and the community at large.

Early Childhood Issues

The managed care system includes mental health services appropriate for young children, provides linkage to IDEA Part C, and covers mental health consultation to early childhood programs. Services for young children and their families are offered in the environment where young children and their families live and play.

