PRIMER HANDS ON - CHILD WELFARE

TRAINING FOR CHILD WELFARE STAKEHOLDERS IN BUILDING SYSTEMS OF CARE

TRAINING GUIDE

MODULE 7
Service Array and Financing

A Skill Building Curriculum
By Sheila A. Pires

In Partnership with Katherine J. Lazear, University of South Florida, and Lisa Conlan, Federation of Families for Children's Mental Health

Based on
Building Systems of Care: A Primer
By Sheila A. Pires
Human Service Collaborative
Washington, D.C.

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De-Brief Day One and "Heads Up" for Day Two

DAY TWO

Introduction to Day Two

The process for Day Two mirrors that of the afternoon of Day One, that is, brief didactic introductions to a number of system of care functions, followed by team work to address key questions about these functions that require strategic thinking, reporting back from teams, and large group discussion. Again, the two-day format does not provide sufficient time to focus on every system of care function discussed in *Building Systems of Care: A Primer*; rather, we are touching upon a number of functions as a way to illustrate a strategic approach to system building.

Day Two also provides you with an opportunity, if you wish, to have lunch in affinity groups; for example, families can lunch together to share experiences and strategies, as can state-level representatives, local level representatives, providers, youth, etc.

Trainer's Notes

If you are conducting the full 2-day training, welcome participants to Day Two.

Take this opportunity to provide and obtain feedback on Day One.

During Day Two, more time will be devoted to teamwork, exploring a number of additional structural challenges for system builders.

Orient participants to the topics and process that will be undertaken during the day and the materials in their manuals.

Remind participants again that the two-day format does not provide enough time to focus on every system of care function discussed in *Building Systems of Care: A Primer*, but that we are touching upon a number of functions as a way to illustrate a strategic approach to system building.

Day Two also provides participants with an opportunity, if they wish, to have lunch in affinity groups. Plan ahead to provide tables with place cards (families, state-level reps., local reps., providers, youth, etc.), indicating which group is to sit where.

MODULE 7

Service Array and Financing

This is material drawn primarily from Section I of *Building Systems of Care: A Primer* (pages 40-47, 103-110, and 79-83).

Function: Array of Services and Supports

Overview

System builders need to determine the types of services and supports that will be available, taking into account system of care principles, such as the importance of a broad, flexible array of services and supports and inclusion of both natural supports and formal services. The array needs to encompass services and supports for parents as well as children and youth. Analysis and mapping of the services and supports available and needed is, by necessity, a collaborative process across agencies and community stakeholders because no one system controls all of the resources needed. Medicaid, for example, is a key entity in covering health and behavioral health services for children and families involved, or at risk for involvement, in child welfare and needs to be at the table. Medicaid officials may refer to "benefit design", rather than services/supports array. "Benefit design" is a term borrowed from insurance practice and managed care and pertains to the types of services and supports that are allowable within systems of care and under which conditions.

Trainer's Notes

Goals
Emphasize to participants that analysis and mapping of services, supports and resources available and needed is a collaborative process across agencies and community stakeholders because no one system controls all the resources needed by children, youth and adult family members.

This is a topic where there are usually many questions, some more focused on specific communities. You may have to let participants know that, to keep to the schedule, you or a co-trainer can meet with them during a break or at the end of the day to answer questions in more detail about their own communities

Method
PowerPoint Presentation; didactic; large group discussion

Training Aids
Microphone if necessary; projector; laptop computer, screen; Slides #1-47 (slides #147-192 *if utilizing the complete curriculum version with no module cover slide*); Handouts 7.1, 7.2, 7.3; flip chart with markers; Case Scenarios; Questions for Team Work.

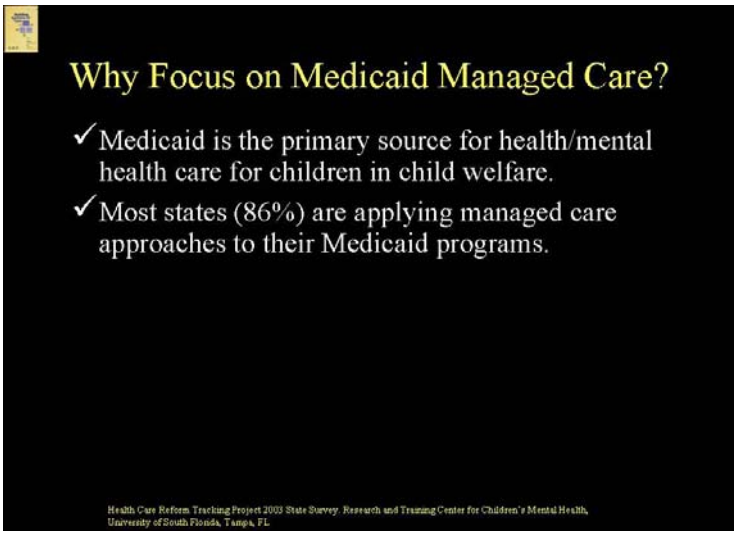
Approximate Time
2 hr. 45 min.

Expected Outcomes
At the end of Module 7, participants should be familiar with:

1) Importance of Medicaid managed care for child welfare
2) Array of services and supports and framework of the

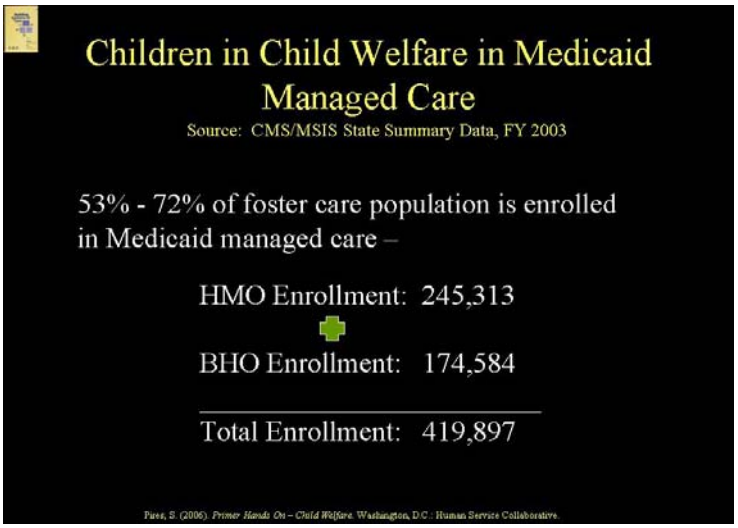
Importance of Medicaid Managed Care for Child Welfare

SLIDE 2 (147)



As Medicaid dollars (and, increasingly, child welfare treatment dollars) have moved into Medicaid managed care arrangements, it is imperative that Medicaid be a collaborative partner and that child welfare stakeholders become very familiar with the Medicaid managed care systems in their states and communities.

SLIDE 3 (148)

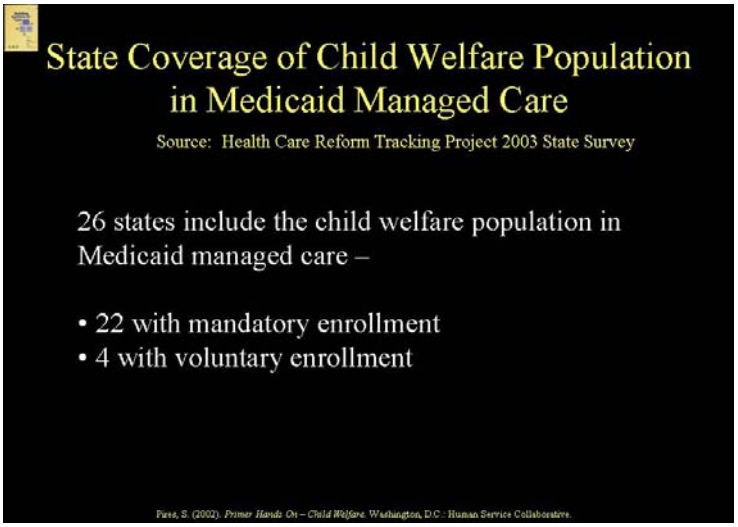


From over half to close to three-quarters of the foster care population is enrolled in Medicaid managed care systems.

National Child Welfare Resource Center for Organizational Improvement (NRCOI) for Assessing and Enhancing the Service Array

3) Examples of services/supports array in systems of care
4) Examples of evidence-based and non-evidenced based practices and practice-based evidence
5) Challenges and incentives to implementing evidence-based practices
6) Universal versus targeted services
7) Culturally competent, family-driven and youth-guided service array
8) Role of family-run organizations
9) Strategies to increase array of services and supports
10) Overview of financing streams and child welfare funding streams and their advantages and disadvantages
11) Creating "win-win" financing scenarios across systems
12) Examples of financing strategies
13) Medicaid options and pros and cons of each
14) Steps in strategic financing analysis
15) Importance of program budget with example
16) Example of field staff "how to pay" matrix.

SLIDE 4 (149)



Over half the states include the child welfare population in their Medicaid managed care arrangements. Child welfare stakeholders need to ensure that Medicaid benefit designs and managed care arrangements take into account the unique needs of children and families involved in child welfare. We will discuss this a bit further in the section on Purchasing/Contracting. The main point here is that partnerships with State Medicaid agencies and Medicaid managed care organizations are critical. Partnerships may be needed both with managed care organizations managing physical and oral health care, as well as with behavioral health organizations managing behavioral health care, depending on the state or community.

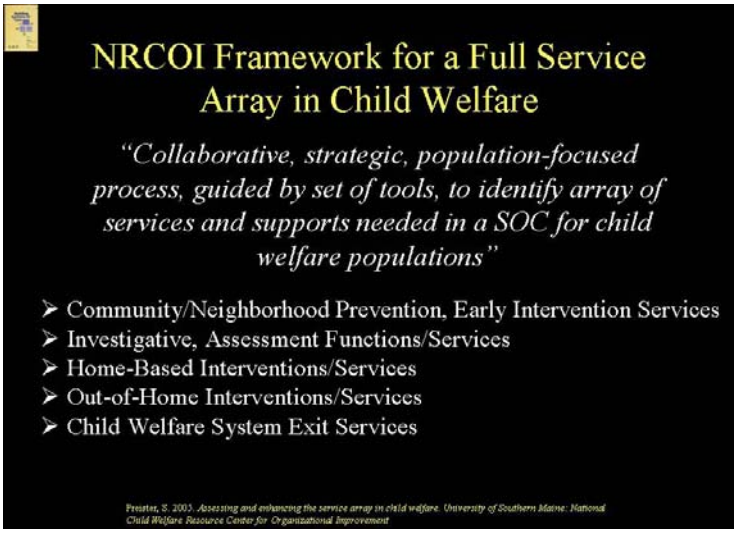
Array of Services and Supports – NRCOI Framework

The National Child Welfare Resource Center for Organizational Improvement (NRCOI), with Steve Preister taking the lead, has developed a collaborative, strategic, population-focused process, guided by a set of tools, to help system builders specifically assess and enhance the array of services and supports needed in a system of care for children and families involved or at risk for involvement in child welfare. It creates a systematic process for system builders, provides a set of tools, and is nested within the Child and Family Services Review's seven outcome areas. The following illustrates the template of services and supports used by NRCOI as a starting point for this process.

Trainer's Notes

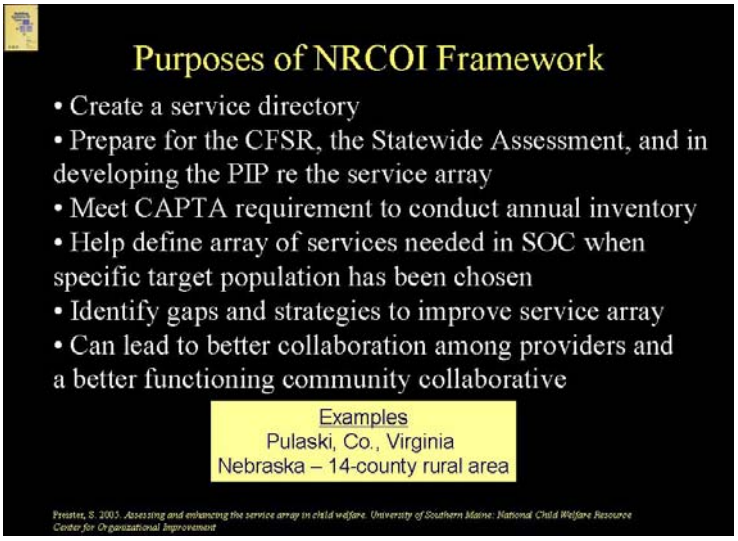
You may have participants with varying degrees of knowledge and experience in this area. Assure participants that Medicaid benefit designs and managed care arrangements will be discussed again later in this section and in the Module on Purchasing/Contracting. The main point to be made here is that partnerships with State Medicaid agencies, and with Medicaid managed care companies, are critical and need to be approached strategically.

SLIDE 5 (150)



Purposes of NRCOI Framework

SLIDE 6 (151)



The NRCOI framework can be used for several purposes, including: to create a services directory; to prepare for CFSR and the Statewide Assessment, and to develop areas of the PIP related to the service array; to meet CAPTA requirements to conduct an annual inventory of services; to help define the services and supports needed for the system of care when the target populations have been defined; to identify gaps and strategies to improve the service array; and, to support better collaboration among providers and with community collaboratives.

Trainer's Notes

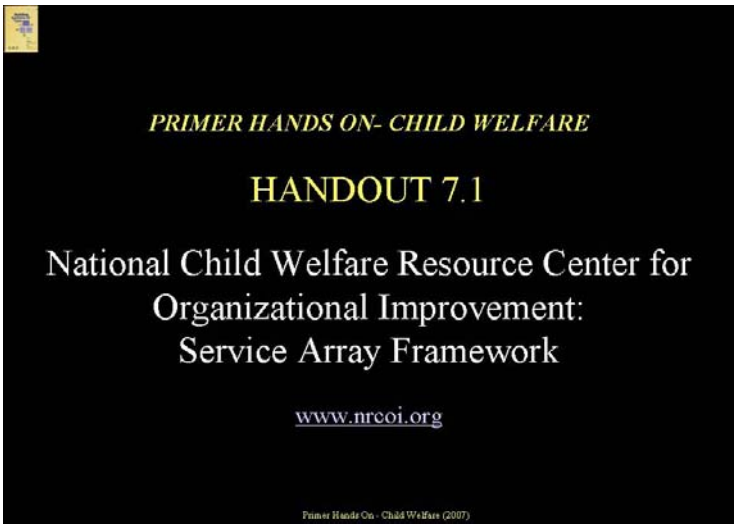
More information about the NRCOI framework can be found at: www. nrcoi.org.

Examples of States/Communities Using NRCOI Service Array Framework

EXAMPLE

Several states and localities are using the **NRCOI** framework and set of tools, with **Nebraska** having already applied it in a 14-county area and **Pulaski County, Virginia**, using it to assess service array issues and strategies for a rural community.

SLIDE 7 (152)



HANDOUT 7.1

Handout 7.1 describes the NRCOI tools and process in detail. **NRCOI's "Service Array Process"** can also help states to conduct the statewide assessment of the service array required for the CFSR process and help states that receive federal Child Abuse Prevention and Treatment Act (CAPTA) funds to meet the requirement to inventory services each year.

Trainer's Notes

Two examples are provided on the slide - Pulaski County, VA and Nebraska. Provide other examples using your own experiences and knowledge of communities and states that have utilized the NRCOI framework effectively.

Refer participants to Handout 7.1 *National Child Welfare Resource Center for Organizational Improvement: Service Array Framework* for additional guidance in developing the service array.

Example of a Broad Array of Services and Supports in a System of Care

SLIDE 8 (153)

EXAMPLE

The **Dawn Project** in **Marion County, Indiana**, utilizes a very broad array of services and supports. The system of care operates with a locus of management accountability for children in or at risk for involvement in child welfare, among others, who have serious behavioral health problems and their families. This service array spans a broad, flexible array of both formal services and informal supports and is made possible through collaborative funding across major systems serving children, youth and families. Note that the array covers services and supports both to children and families, including basic supports like transportation, food, and help with utility bills, as well as formal services to parents, such as parent skills training, as well as services and supports to children.

Evidence-Based and Effective Practices

Children's services – in child welfare, mental health and substance abuse, juvenile justice, education, early intervention and other arenas - have benefited in the past decade from a growing research base, including research on evidence-based practices, that is, practices that show evidence of effectiveness through carefully controlled, random clinical trials. The field also is benefiting from a growing literature about promising approaches, which have not yet had the benefit of scientific research but which, experientially, are demonstrating effective outcomes. This is sometimes referred to as *practice-based evidence*. The National Association of Public Child Welfare Administrators (NAPCWA) published a "Guide for Child Welfare Administrators on Evidence-Based

Trainer's Notes

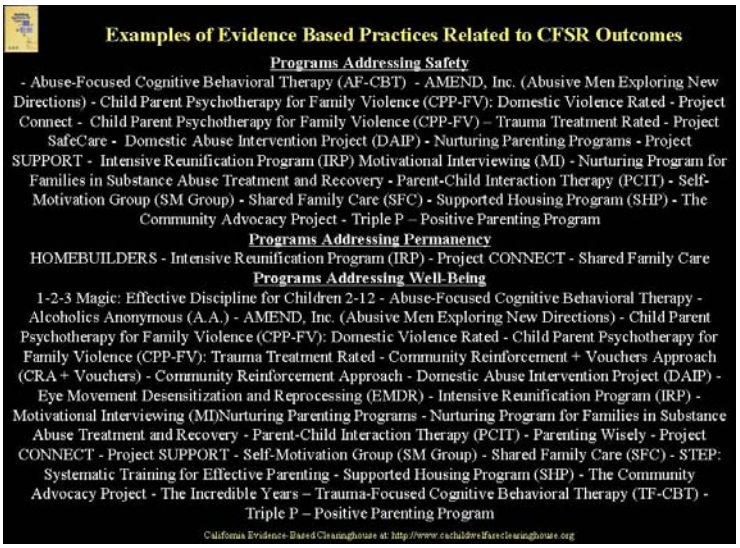
You may want to share other examples from your own experience of systems of care using a broad array of services and supports for children, youth and families involved or at risk for involvement in child welfare.

This discussion returns to the topic of evidence-based and effective practices, raised earlier in the Module on Context-Setting.

Practice", which discusses both evidence-based and promising practices and includes a list of other relevant websites on this topic. The NAPCWA Guide can be found at: www. aphsa.org.

Examples of Evidence Based Practices for Families and Children Involved in Child Welfare

SLIDE 9 (154)



The California Evidence-Based Clearinghouse (http://www.cachildwelfareclearinghouse.org) has identified numerous examples of evidence based practices related to CFSR outcomes. They include:

<u>Programs Addressing Safety</u>

Abuse-Focused Cognitive Behavioral Therapy (AF-CBT)
AMEND, Inc. (Abusive Men Exploring New Directions)
Child Parent Psychotherapy for Family Violence (CPP-FV) – Domestic Violence Rated
Child Parent Psychotherapy for Family Violence (CPP-FV) – Trauma Treatment Rated
Domestic Abuse Intervention Project (DAIP)
Intensive Reunification Program (IRP)Motivational Interviewing (MI)
Nurturing Parenting Programs
Nurturing Program for Families in Substance Abuse Treatment and Recovery
Parent-Child Interaction Therapy (PCIT)
Project Connect
Project SafeCare
Project SUPPORT
Self-Motivation Group (SM Group)

Trainer's Notes

You may want to offer examples from your own experience as to states and communities that are using evidence-based practices for children and families in child welfare.

More information about evidence-based practices in child welfare can be found at:
Child Welfare League of America's *Research to Practice Initiative* (**http://www.cwla.org/programs/r2p/default.htm**)

University of Kansas School of Social Welfare's *Evidence-Based Practice Tool* (**http://www.rom.ku.edu/EBP_Main.asp**)

More information on the Kauffman Foundation's report, *Findings of the Kauffman Best Practices Project*, can be found at: **http://www.chadwickcenter.org**

Information about evidence-based practices in the area of mental health and substance abuse treatment for youth and for adults can be found at: **http://www.modelprograms.samhsa.gov**

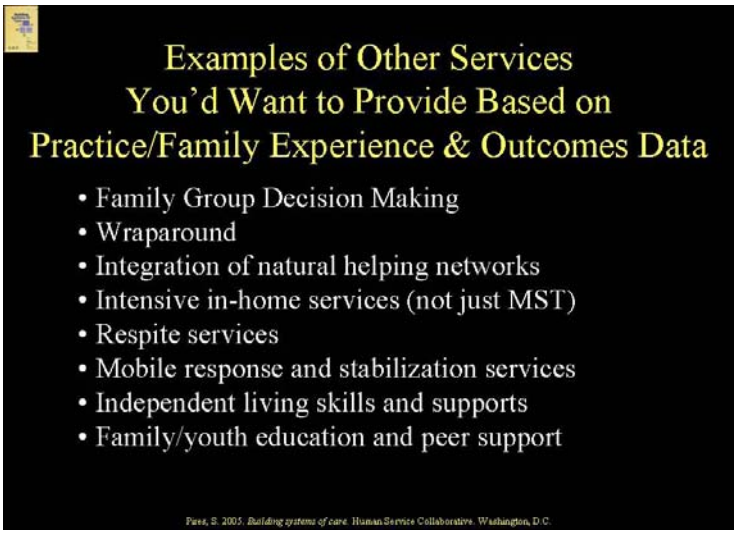
Shared Family Care (SFC)
Supported Housing Program (SHP)
The Community Advocacy Project
Triple P – Positive Parenting Program
Programs Addressing Permanency
HOMEBUILDERS
Intensive Reunification Program (IRP)
Project CONNECT
Shared Family Care (SFC)
Programs Addressing Well-Being
1-2-3 Magic: Effective Discipline for Children 2-12
Abuse-Focused Cognitive Behavioral Therapy (AF-CBT)
Alcoholics Anonymous (A.A.)
AMEND, Inc. (Abusive Men Exploring New Directions)
Child Parent Psychotherapy for Family Violence (CPP-FV) – Domestic Violence Rated
Child Parent Psychotherapy for Family Violence (CPP-FV) – Trauma Treatment Rated
Community Reinforcement + Vouchers Approach (CRA + Vouchers)
Community Reinforcement Approach
Domestic Abuse Intervention Project (DAIP)
Eye Movement Desensitization and Reprocessing (EMDR)
Intensive Reunification Program (IRP)Motivational Interviewing (MI)
Nurturing Parenting Programs
Nurturing Program for Families in Substance Abuse Treatment and Recovery
Parent-Child Interaction Therapy (PCIT)
Parenting Wisely
Project CONNECT
Project SUPPORT
Self-Motivation Group (SM Group)
Shared Family Care (SFC)
STEP: Systematic Training for Effective Parenting
Supported Housing Program (SHP)
The Community Advocacy Project
The Incredible Years
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
Triple P – Positive Parenting Program

In addition to evidence-based practices identified by the California Evidence-Based Clearinghouse, other examples of evidence-based practices that have had the benefit of research dollars include: those for children involved or at risk for involvement in the child welfare system exposed to trauma, which were identified by the National Child Traumatic Stress Network and included in a report issued by the Kauffman Foundation, - i.e., Trauma-Focused Cognitive Behavioral Therapy, Abuse-

Trainer's Notes

Focused Cognitive Behavioral Therapy, Parent-Child Interaction Therapy – and others that have been identified through the federal Substance Abuse and Mental Health Services Administration, such as Functional Family Therapy, the Matrix Model for methamphetamine abuse, Multisystemic Therapy, Multidimensional Foster Care, and Intensive Care Management.

SLIDE 10 (155)



Examples of services that are promising and show evidence of effectiveness based on the experience of families, providers and administrators, and outcome data include: family group conferencing, wraparound, intensive home-based services, respite services, mobile response and stabilization services, independent living skills and supports, and family/youth peer mentors.

Trainer's Notes

Remind participants that promising practices – or practice-based evidence – also are needed within systems of care, as discussed on Day One in the Context-Setting Module.

You may want to share other examples of practice-based evidence from your own experience.

Examples of Non-Evidence Based Practices

SLIDE 11 (156)

Services that do not tend to show up in the evidence-based practice literature as having sustainable outcomes for children, although they may be standard practice, include: residential treatment, group homes, traditional office-based "talk" therapy, and day treatment. Interestingly, these often are the services used most frequently for children with the most serious needs, and some carry very high costs.

SLIDE 12 (157)

Examples from Hawaii's List of Evidence Based Practices

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

HA Dept. of Health, Child & Adolescent Division (2005). Available from: http://www.hawaii.gov/health/mentalhealth/camhd

Trainer's Notes

The discussion moves here from what are evidence-based and promising practices to practices that have known risks to them.

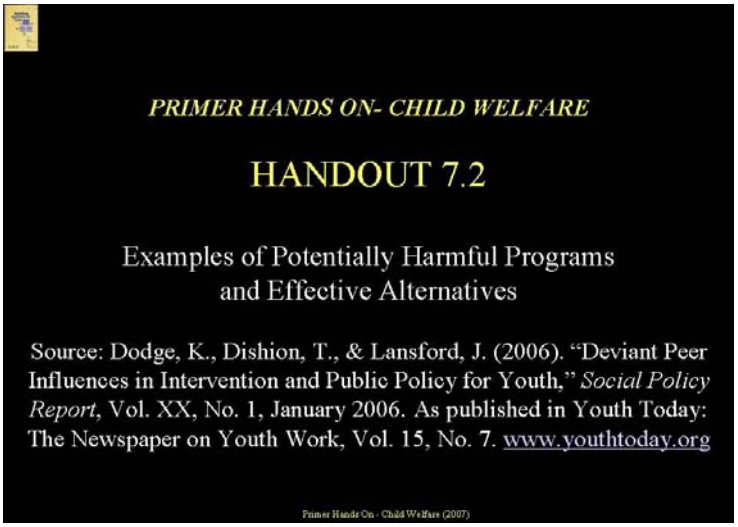
Hawaii is an example of a state that is systematically tracking, not only evidence-based practices, but practices that carry known risks. This slide also can be used to point out the limitations of focusing only on evidence-based practices (and not promising as well). For example, the Hawaii process identified only Multisystemic Therapy as effective with youth with sexual offenses. However, several systems of care are getting good outcomes with this population using a highly individualized, wraparound approach, such as Wraparound Milwaukee and Parent Support Network of Georgia. You may have other examples you wish to use from your own experience to illustrate this point.

EXAMPLE

Hawaii provides us with an example of efforts to identify both effective practices for children presenting with specific problems – for example, cognitive behavior therapy for children with anxiety - as well as practices that carry documented risks, such as group therapy for youth with delinquent behaviors.

Trainer's Notes

SLIDE 13 (158)



Refer participants to Handout 7.2: Example of Potentially Harmful Programs and Effective Alternatives.

HANDOUT 7.2

Handout 7.2 summarizes recent study findings about services that the authors found carry a risk to children and youth involved in child welfare and other systems and more effective alternatives.

Challenges to Implementing Evidence-Based Practices (EBPs)

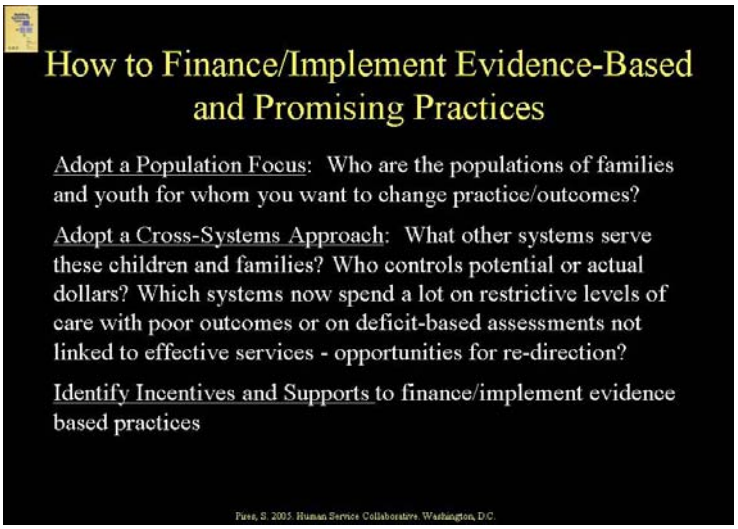
SLIDE 14 (159)

Point out that implementation of evidence-based and promising practices requires commitment of resources to create a supportive infrastructure, for example, to train and coach staff and providers, to monitor fidelity and track outcomes.

Some of the challenges to implementing evidence-based and promising practices within a system of care include: the need for training, consultation, coaching, provider capacity development, fidelity monitoring, outcomes tracking, and policy and financing changes.

Strategies and Incentives for Implementing Evidence-Based Practices

SLIDE 15 (160)



Several strategies for addressing these challenges, which mirror system of care approaches, include: adopting a population focus across systems and identifying incentives to the various systems for collaborating.

SLIDE 16 (161)

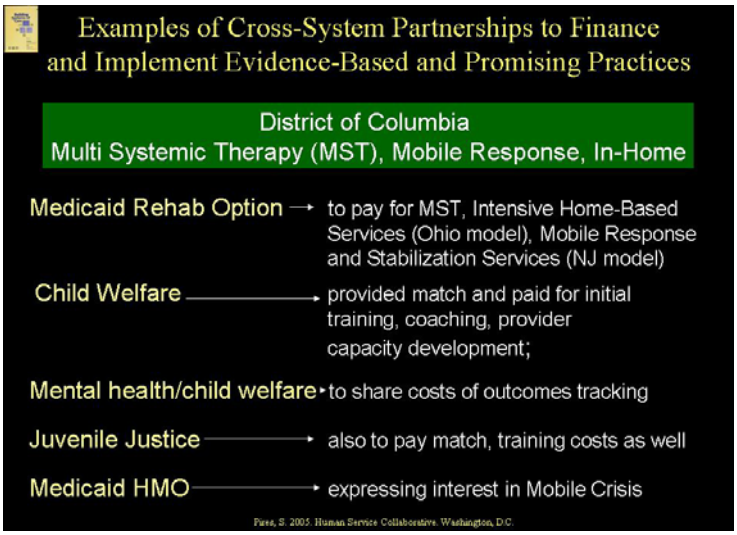
Trainer's Notes

Note the synergy between the strategies for implementing evidence-based practices and those for developing systems of care.

Examples of types of incentives for the various systems that need to be engaged in this effort include: for Medicaid, slowing the rate of growth in inpatient, emergency room, psychiatric residential treatment, and pharmacy costs; for child welfare, meeting ASFA outcomes and PIP objectives, such as reducing out of home placements and lengths of stay; for juvenile justice, creating alternatives to detention; for mental health, creating a more effective delivery system; for education, reducing special education expenditures.

Trainer's Notes

SLIDE 17 (162)



Point out to participants that a key strategy in building systems of care is to identify "win-win" scenarios for the various systems that serve children and families.

You may have other examples you want to share from your own experience about "win-win" partnerships across systems to develop evidence-based practices for children and families in child welfare.

EXAMPLE

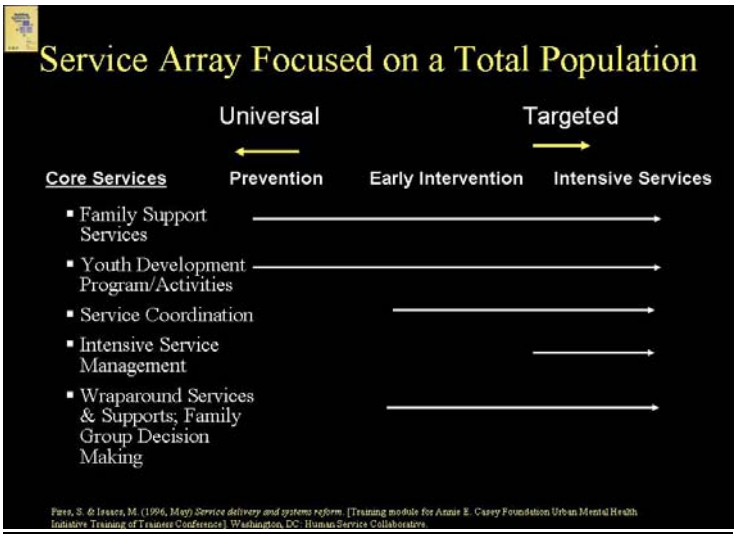
The **District of Columbia** provides an example of a cross-system partnership to implement several new evidence-based and promising practices for children in child welfare, including Multisystemic Therapy (MST), mobile response and stabilization, and intensive home-based services.

Universal Versus Targeted Services

Particularly if the system of care is focusing on a total population of children and families (for example, all children and families in a county or all Medicaid-eligible children or all children and families in or at risk for child welfare involvement in a given community), it needs to encompass both universal (i.e. geared to all children and families, including prevention and early intervention services) and targeted services and supports (i.e. geared to children and families identified with or at risk for serious problems, including early intervention and treatment services). The following graphic illustrates this point by showing examples of a service array spanning universal through targeted interventions focused on a "total population".

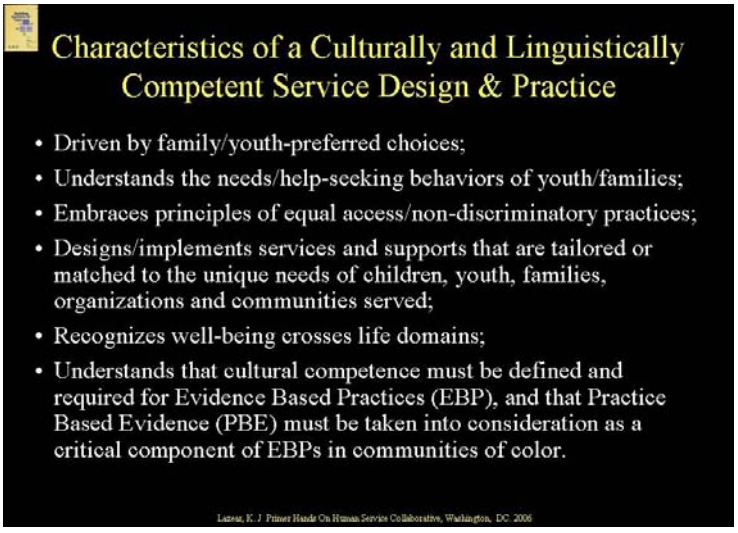
To illustrate this point, you can also refer participants back to the three case scenarios to think about how the services/supports array might differ in its span of universal through targeted services in each of the three system of care communities.

SLIDE 18 (163)



Culturally Competent, Family/Youth-Driven Service Array

SLIDE 19 (165)



Families/youth and culturally diverse constituencies need to be involved in the design of the service array, and the services and supports need to reflect the priorities of these key stakeholders. The availability of appropriate services and supports will send a powerful message about values and goals. If it is a narrow, inflexible array and fails to include non-traditional supports, families, youth and culturally diverse constituencies are likely to question the sincerity of system builders. Some tenets of culturally competent service design and practice include: identifying and understanding the needs and help-seeking behaviors of

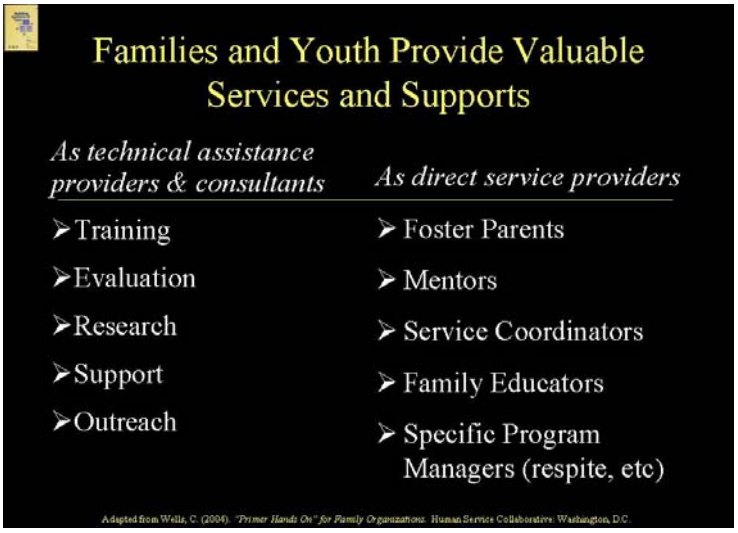
Trainer's Notes

You may want to share examples form your own experience of culturally and linguistically competent service delivery approaches.

culturally and linguistically diverse families and youth; embracing the principles of equal access and non-discrimination; implementing services and supports that are tailored or matched to the unique needs of culturally diverse families and youth; incorporating family and youth choice; recognizing that well-being crosses life domains.

Role of Family-Run Organizations

SLIDE 20 (165)



Youth and family or youth directed organizations play an important and culturally competent role in the delivery of services as providers, trainers, evaluators, outreach workers, etc. Families and youth are taking on paid and stipend positions as support group facilitators, family interviewers, and mentors. Foster parents and birth parents are learning new shared parenting practices. Family members who have been successfully re-unified with their children are mentoring and supporting other families entering the system of care for child welfare needs. Family leaders and youth who have aged out of the system are becoming service coordinators and service providers and carry a deep sensitivity to supporting families and youth in need. Youth who have had experience in foster and group homes are participating in licensing visits to group care facilities and are serving on national initiatives to improve practices in residential treatment facilities.

EXAMPLE

In **Rhode Island**, the Parent Support Network has hired a family mentor who works specifically with families involved with child welfare to mentor them through the service planning process, and provide ongoing emotional support, empowerment and education. The person in this position works very closely with child welfare family service workers and

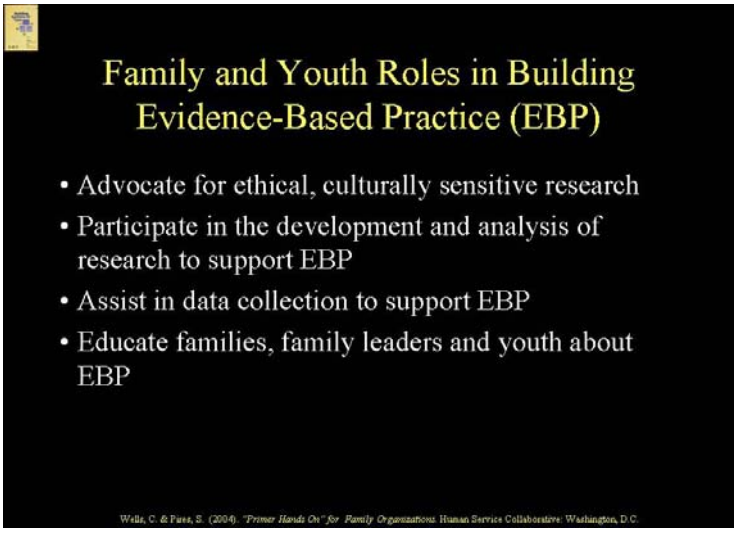
Trainer's Notes

Review the slide with participants and share examples, from your own experience, of these services and support roles provided by families and youth with identifying leadership of birth, kin, foster and adoptive families and youth in these roles. Ask participants to discuss emerging roles of families and youth as providers in their respective states, counties, tribes or territories.

families who have successfully preserved and reunified their family to become more involved in participating in quality assurance, mentoring or other roles like hers.

Family/Youth Role in Evidence-Based Practice Development

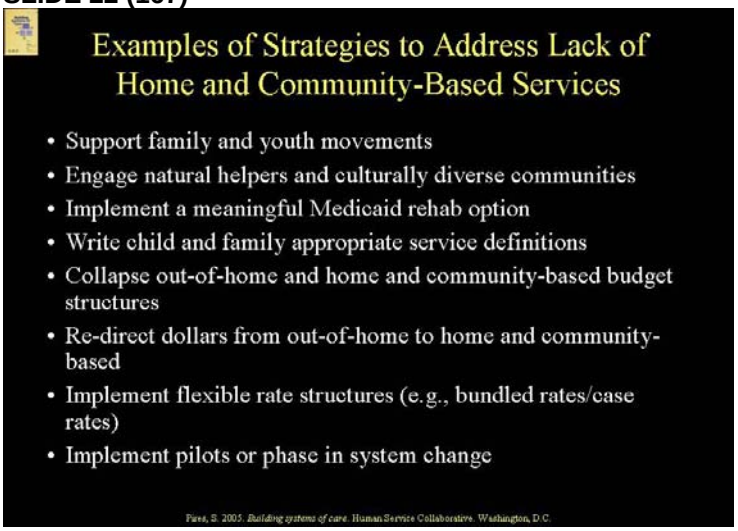
SLIDE 21 (166)



There are various ways in which families and youth can partner in this effort, including: advocating for ethical, culturally sensitive research; participating in the development and analysis of research to support evidence-based practices (EBPs); assisting in data collection to support EBPs; and, educating families and youth about EBPs.

Strategies to Increase Array of Services and Supports

SLIDE 22 (167)



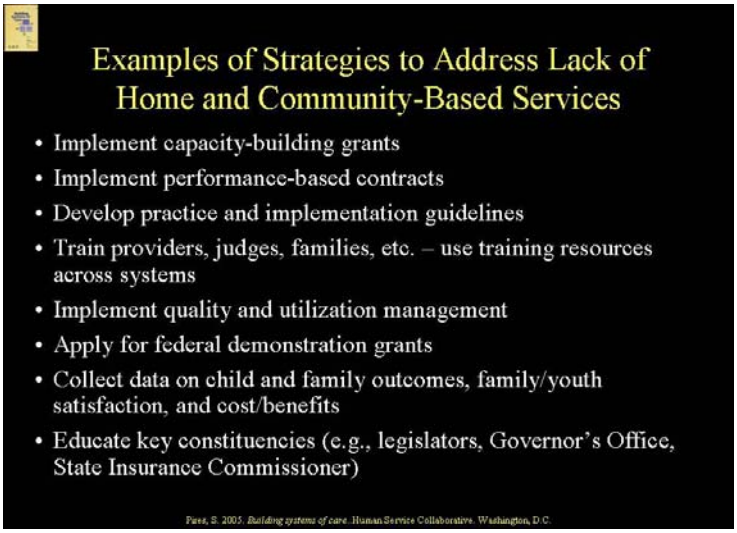
Trainer's Notes

It also is important to note that families and youth need to play a role in the development and dissemination of evidence-based practices. You may want to share an example from your experience of families and/or youth being involved in the development or analysis of evidence-based practices.

The following two slides list examples of strategies communities have used to address their lack of home and community-based services. You might want to provide specific examples to illustrate these strategies, based on your knowledge and experiences.

SLIDE 23 (168)

Trainer's Notes



Virtually every community lacks a sufficient array of services and supports. Strategies for increasing home and community-based service capacity include: support family and youth movements so that families and youth can organize to advocate for services; engage natural helpers and culturally diverse communities to identify and utilize informal supports; implement a meaningful Rehabilitation Services Option under Medicaid (for example, as Arizona has done); collapse out-of-home and community-based budget structures so that savings in reduced out-of-home placements can be used to expand community services (as Massachusetts is doing); re-direct dollars from "deep end" spending, such as on out of home placements, to community services; implement flexible rate structures, such as case rates (as Wraparound Milwaukee is doing); implement capacity-building grants for providers; implement performance-based contracts; develop practice guidelines; orient and train key stakeholders, such as judges, CASA volunteers, providers; implement quality and utilization management; apply for federal system of care demonstration grants; collect data on outcomes, family and youth satisfaction and on cost/benefit; educate key policymakers, such as Governor's office staff and legislators. With the research supporting home and community-based services and system of care principles, arguments can be advanced regarding the need to change financing policies, such as Medicaid, provider contracts and incentives, and training agendas for staff and other stakeholders.

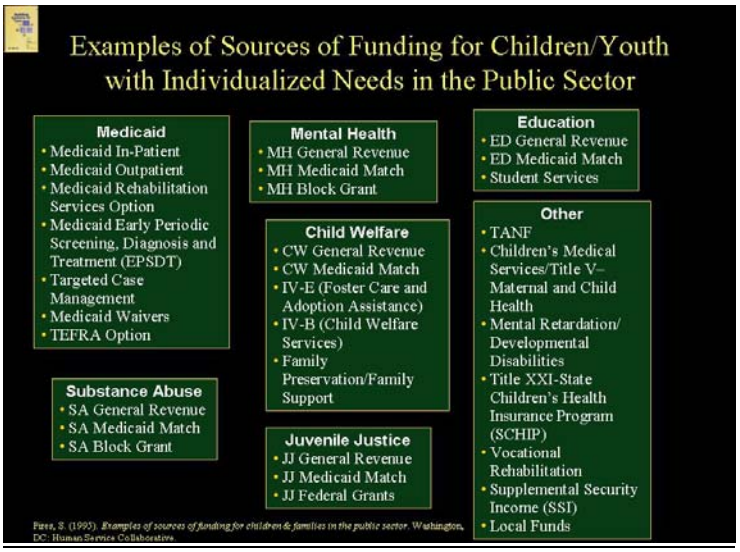
You may have additional examples to illustrate use of these various strategies to expand the availability of home and community based services and supports.

Function: Financing

Overview of Financing Streams

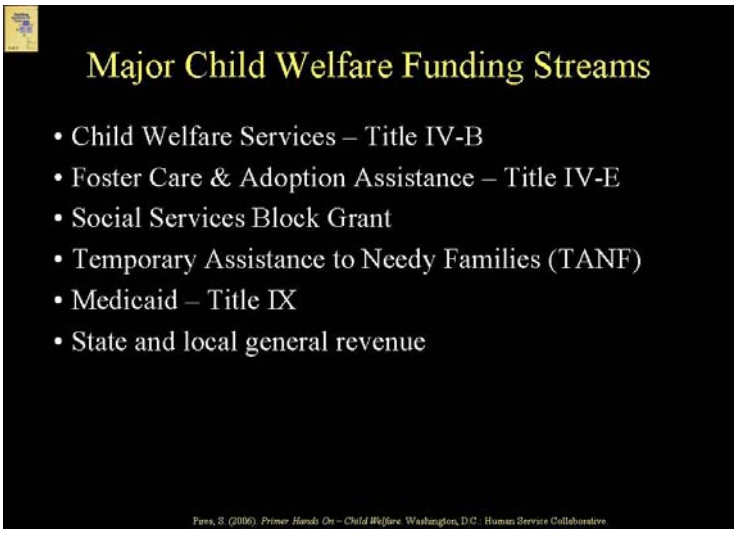
The following graphic depicts examples of funding for children and families in the public sector. These funding streams tend to operate categorically and are protected by different interest groups. The traditional rigidity and lack of coordination among these funding streams pose daunting challenges to families, providers, and administrators alike.

SLIDE 24 (169)



Major Child Welfare Funding Streams

SLIDE 25 (170)



Trainer's Notes

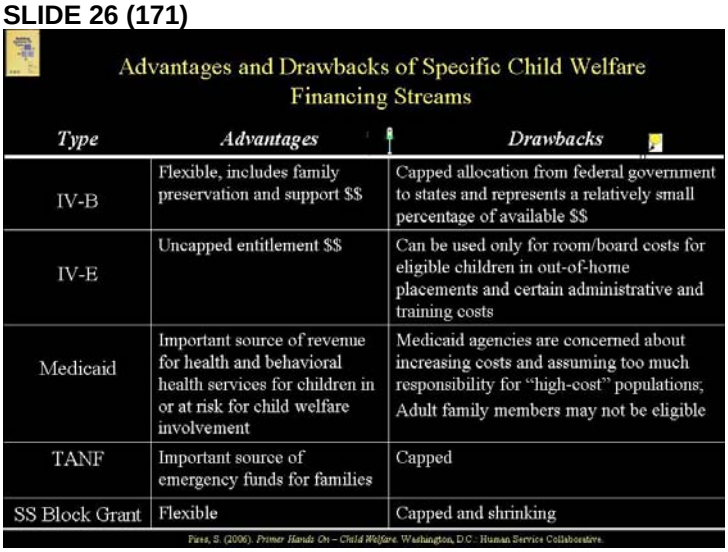
You may have a diverse mix of stakeholders in your audience, so plan this financing presentation strategically. Some topics will require more detail while others may only require a cursory review. Also, a member of your training team should be familiar with current funding availability and limitations, for example, IV-E and Medicaid limitations

Trainer's Notes

The major funding streams that are typically used for children and families in or at risk for involvement in child welfare, and some of their advantages and limitations, include: Child Welfare Services-Title IV-B of the Social Security Act (SSA) (capped, flexible, small); Foster Care and Adoption Assistance-Title IV-E of the SSA (uncapped but restricted); the Social Services Block Grant (flexible but capped and increasingly limited); Temporary Assistance to Needy Families (TANF) (important source of emergency funds for families but capped); Medicaid-Title IX of the SSA (critical source of medical and behavioral health funds for children but depends on state plan and under increasing scrutiny by federal Medicaid agency); and state and local general revenue.

Advantages and Disadvantages of Specific Funding Streams

SLIDE 26 (171)



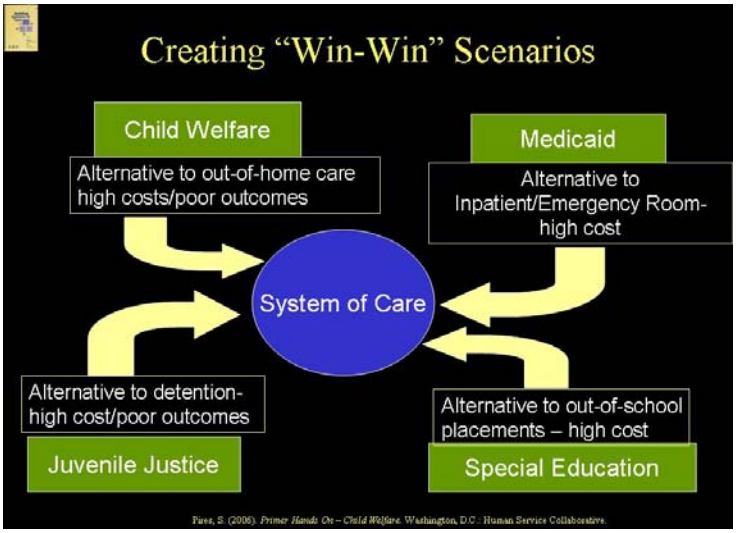
Point out to participants that all funding streams carry opportunities and limitations. Part of the strategic analysis that system builders need to undertake is to ascertain the possibilities of the various funding streams in their particular states and communities.

Each of these financing streams has its particular advantages and drawbacks. For example, while IV-B funds are flexible and include family preservation and support dollars, IV-B is a capped allocation from the federal government to states and represents a relatively small percentage of available dollars. While IV-E funds are uncapped entitlement dollars, they can be used only for room and board costs for eligible children in out-of-home placements and certain administrative and training costs. One of the attractions of the federal IV-E waiver program (now ended) was that it allowed states and localities to "blend" IV-B and IV-E dollars to allow for more flexibility and potential revenue for home and community based services and supports; in return, cost neutrality had to be shown, which represented a risk to states if they could not redirect (reduce) out of home expenditures. Medicaid is an important source of revenue for health and behavioral health services for children in or at risk for child welfare involvement, but Medicaid agencies are concerned about

increasing costs and assuming too much responsibility for "high-cost" populations. In addition, adult family members may not be eligible for Medicaid.

Creating "Win-Win" Financing Scenarios

SLIDE 27 (172)



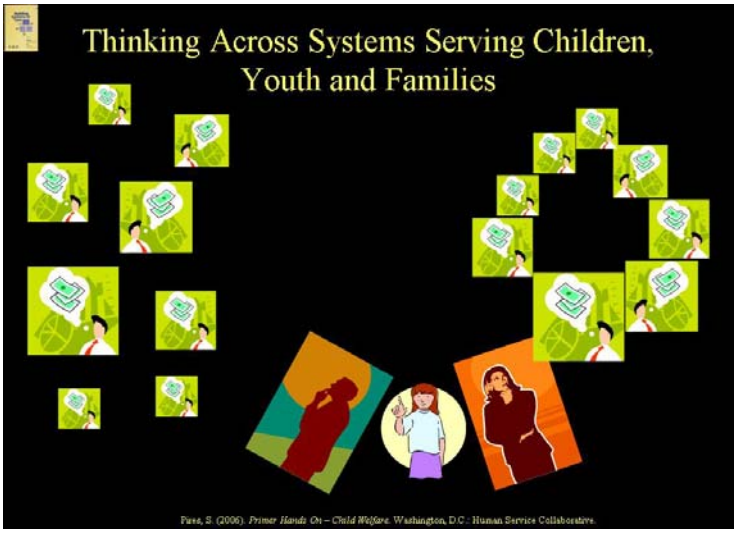
Part of the strategic challenge for system builders is to understand these funding streams, who controls them, what they are buying, and what *other systems'* issues are. Part of the strategic challenge is to understand how to use these various funding streams to support systems of care and then to convince various interest groups that use of these funds within the system of care can be a "win-win" situation. For example, child welfare directors might be convinced that use of child welfare general revenues to support alternatives to residential treatment through the system of care makes more sense than their continuing to spend large amounts on residential treatment with little evidence of efficacy. State Medicaid directors might be convinced that the home and community-based supports available through the system of care – made possible by implementing an effective Rehabilitation Services Option in Medicaid – will help to reduce expenditures on hospital and emergency room admissions, lengths of stay or recidivism rates. Similarly, the system of care may provide a viable alternative to incarceration for juveniles involved in the delinquency system and thus be attractive to juvenile justice stakeholders. School officials could utilize the home and community-based services and supports as alternatives to removing children from regular classrooms. This strategic analysis will vary from one community to another. The more system builders know about the various funding streams and who controls them, the more comprehensive can their analysis and financing strategies be.

Trainer's Notes

Point out to participants (as noted earlier) that part of a strategic approach to financing is to figure out what the "win-win" scenarios are for various systems serving children and families to maximize resources for the system of care.

Thinking of Financing Across Systems

SLIDE 28 (173)



One of the factors that make financing systems of care challenging is that system builders are thinking of benefits *across* child-serving systems, whereas (unless they are part of the system building effort) other systems are thinking about the benefits to their own system. For example, state Medicaid directors may not be so interested in reducing expenditures on residential placements if Medicaid plays no role in funding residential care. Medicaid directors may become interested, however, if there is a groundswell of support for movement to or expansion of the Rehabilitation Services Option to cover residential treatment.

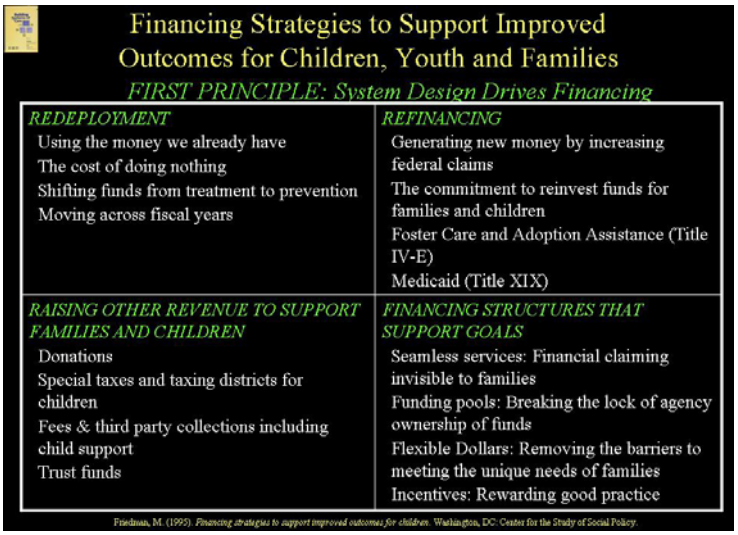
While system builders must think strategically about what will appeal to each interest group and agency director that controls a funding stream, they must also think strategically about how to approach legislators and governors' executive staff, who should be more concerned about spending and outcomes across systems than individual agency directors may be.

Trainer's Notes

Point out the intricacies of thinking strategically across systems about who controls dollars and what incentives exist for spending dollars differently.

Financing Strategies and Structures

SLIDE 29 (174)



There are various types of financing strategies and structures used in systems of care, but they all begin with the basic principle that the system design itself needs to drive the financing strategies and structures, not the other way around. (This also means that system builders have developed the system design, and it is clear to stakeholders.) For the Annie E. Casey Foundation, Mark Friedman identified a number of key financing strategies critical to systems of care, including:

- **Redeployment of existing dollars**: In most states and communities, there are very few new dollars for services to children and families, which means that to finance new types of services, dollars must be re-directed from areas that are producing high costs or poor outcomes, such as out-of-home placements.
- **Refinancing to maximize federal match dollars**: This includes maximizing Medicaid dollars by expanding services covered under Medicaid or increasing the enrollment of eligible children and maximizing Title IV-E by ensuring effective draw-down of federal dollars for all IV-E eligible children and for the various activities that are allowable under IV-E, such as case management and training.
- **Raising new revenue**: This includes various efforts to generate new funds, such as advocacy with state legislatures and taxpayer referenda that create special tax revenue for children's services – for example, Proposition 63 in California, which creates an additional tax on the incomes of those earning more than $1 million a year, with the revenue earmarked for mental health services for adults and children.
- **Creation of new structures**, such as pooled, braided, and blended

Trainer's Notes

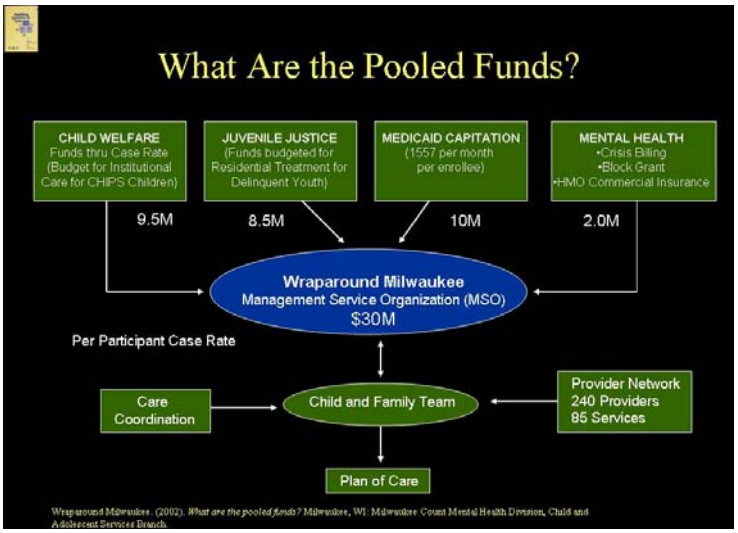
You may want to share examples from your own experience that illustrate these major financing strategies, i.e., redirection; refinancing; and raising new revenue.

It is important here to remind participants that planning and implementing financing strategies is a learning process. Financing plans need to be continually assessed as new resources become available or are lost, current policies are changed that affect funding, new policies are planned and implemented, or as planned strategies lead to successes and/or failures.

funding and collapsing out of home and community service budget line items so that "savings" in out-of-home spending can be used for home and community services. Strategically, system builders need to obtain assurances from policy makers that "savings" generated by reducing out of home placements or lengths of stay or out-of-school day placements will revert back to the system of care (and not go to other purposes, such as state deficit reduction or the building of highways).

Examples of Financing Strategies

SLIDE 30 (175)



EXAMPLE

In **Milwaukee, Wisconsin,** Wraparound Milwaukee is one example of a system of care using blended funding and redirecting spending on residential treatment from child welfare to community services and supports. Milwaukee estimated that, without having re-designed its system and re-directed dollars, child welfare spending on residential treatment would have increased from $18m in 1996 to $43 m today; instead, Milwaukee is spending less on residential treatment today than in 1996 and serving more children.

To prevent disruptions in placements of children in foster care, **Milwaukee** also used combined funding to finance a Mobile Urgent Treatment Team (MUTT), which can work with children and families in any setting and over a flexible 30-day time period. The child welfare system provided general revenue funds, which Wraparound Milwaukee can maximize by billing Medicaid for Medicaid-eligible children. For example, child welfare provided $450,000 in funding; Wraparound Milwaukee is able to generate another $200,000 in Federal Medicaid match, creating a $650,000 mobile crisis capacity for children and families

Trainer's Notes

These are examples of financing structures that illustrate financing strategies.

For more information about the examples cited here, contact:

Wraparound Milwaukee at: www.milwaukeecounty.org

Central Nebraska Integrated Care Coordination Unit at: www.regionsix.com/iccu.htm

El Paso County, CO at: www.cosystemofcare.org

North Carolina at: www.unc.edu/fcrp/fp/fp_vol7no2/reform.htm

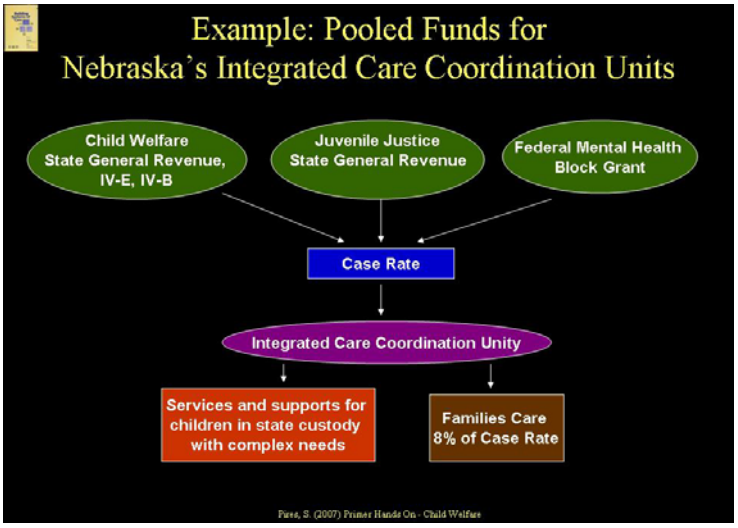
Cuyahoga County at: www.fcfc.cuyahogacounty.us/services.htm

Maryland at: www.goc.state.md.us

Children's Trust Fund in Miami at: www.thechildrenstrust.org

in child welfare. Use of MUTT has reduced the placement disruption rate in child welfare from 65% to 38%.

SLIDE 31 (176)



EXAMPLE

Central Nebraska Integrated Care Coordination Unit is another example of pooled funds to reduce out-of-home placements and re-direct spending to home and community-based services and supports for children in state custody with complex needs. This approach has led to a reduction in the percentage of children living in group or residential care (from 35.8% to 5.4%), a 2.3% reduction in children "stuck" in hospital care, and an increase in the percentage of children living in the community (from 41.4% to 87.1% reunited with family, living with relatives, in family foster care, or in independent living.

Example

El Paso County, Colorado integrated child welfare and cash assistance programs to better utilize Temporary Assistance to Needy Families (TANF) as a primary prevention program for families involved and at risk for involvement in child welfare. For example, the county combined Title IV-B family preservation services with TANF-funded services such as substance abuse counseling and domestic violence prevention. The county also used TANF to augment supports to grandparents raising children.

Example

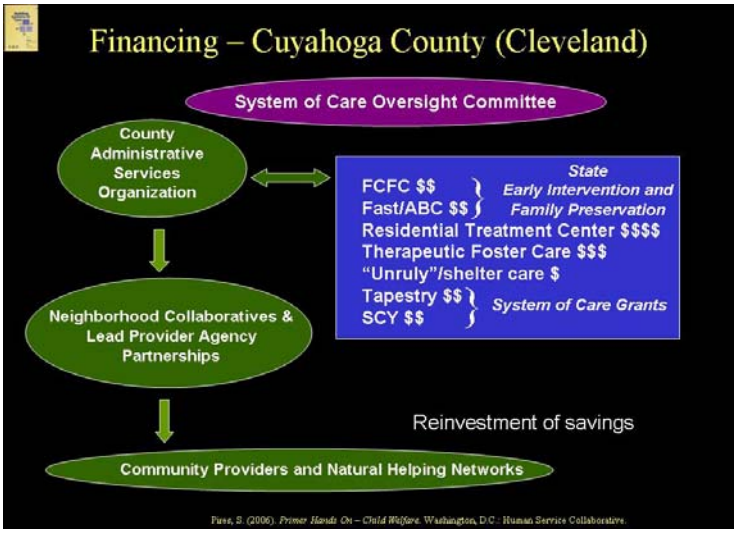
The **North Carolina** State System of Care Collaborative has pooled dollars to support training across systems in a family-centered practice model, develop curricula, and build and maintain a website for communication across stakeholders. They also combined funding from their system of care grant with county mental health funding to finance

Trainer's Notes

You may want to share other examples from your own experience of financing strategies for systems of care.

family advocate positions.

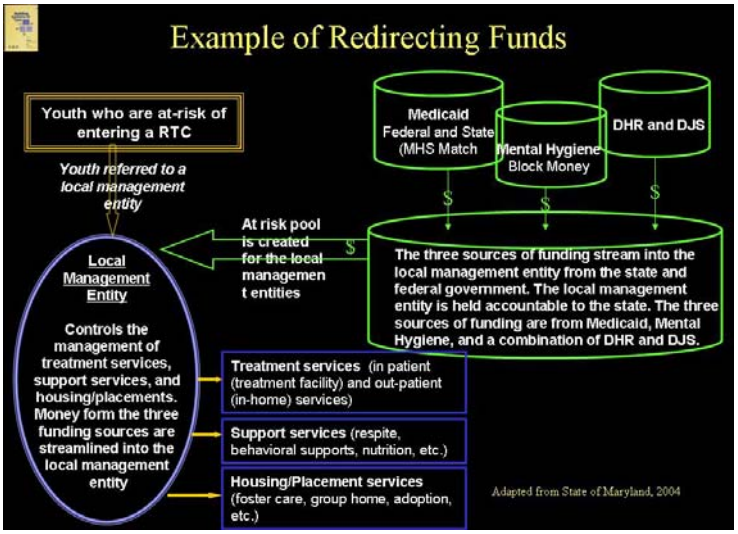
SLIDE 32 (177)



EXAMPLE

Cuyahoga County provides an example of a system of care using braided or "virtual blended" dollars from child welfare and other systems on behalf of several different populations of children, youth and families involved, or at risk for involvement, in child welfare and other systems.

SLIDE 33 (178)



EXAMPLE

Maryland is an example of a state initiative to re-direct Medicaid dollars from residential treatment to local management entities. Maryland will redirect Medicaid dollars spent on residential treatment to local

Trainer's Notes

There may be other examples of financing strategies from child welfare system of care grants that you wish to share.

management entities, using a 1915 (b) Medicaid managed care waiver for Medicaid-eligible children and a 1915 (c) Home and Community Based Waiver to cover non Medicaid-eligible children and families. (The 1915 (c) waiver is through the Center for Medicare and Medicaid Services federal demonstration grant program to allow use of home and community based waivers for residential treatment.)

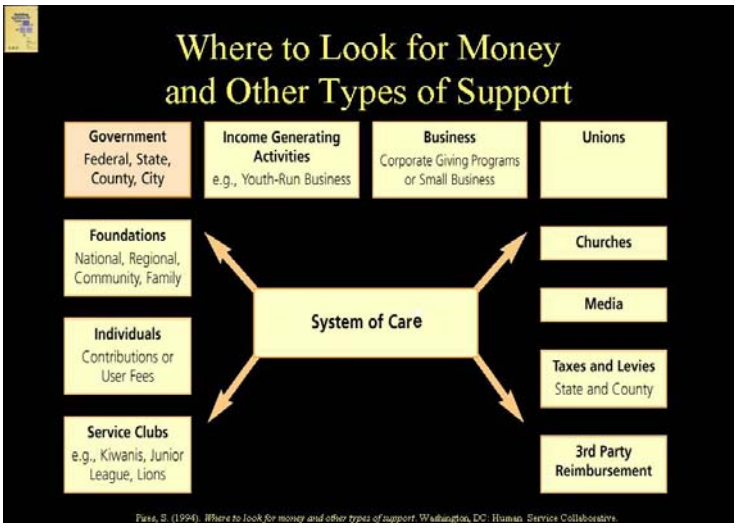
A longer range strategy is a taxpayer referendum to earmark taxpayer dollars, through, for example, allocating a percentage of sales, property or income taxes to children's services.

EXAMPLE

The Children's Trust Fund in **Miami**, **Dade County, Florida**, created through a taxpayer referendum, generates over $30 million a year in funding for early intervention. **Spokane County, Washington**, through a taxpayer referendum, is levying a 0.1% sales tax to generate over $6 million new, flexible dollars for mental health services (adult and child).

Comprehensive Strategy

SLIDE 34 (179)



Part of a comprehensive financing strategy is to draw on multiple funding sources. While government funding streams are the largest, other sources of funds – i.e., foundations, businesses, donations, etc. – are also important. They are often sources of flexible dollars and lead to broader community buy-in for the system building effort. The following is a graphic depiction from federal system of care sites regarding the diversity of funding support being tapped in these sites.

Trainer's Notes

Provide any additional examples of taxpayer referenda that have generated special levies for children's services.

Convey to participants that the size of the box in this slide does not correspond in any way to the amount of money provided by that source. For example, while both boxes are of equal size in the illustration, "Government" is the largest source of financial support, while the "Service Clubs" may provide a minimum amount. All of these financing sources are critical for different reasons. For example, support from faith-based organizations and businesses creates buy-in from the community and may offer resources that families find most helpful. While all are important, it is essential for system builders to understand and revamp the ways in which governmental funding streams are utilized as these are the largest sources of funding and perpetuate more categorical, rigid approaches if not re-structured.

SLIDES 35-37 (180-182)

DIVERSITY OF FEDERAL GRANT SITE FUNDING

SOURCE	SYSTEM	DESCRIPTION
State	Mental Health	General fund, Medicaid (including FFS/managed care/waivers), federal mental health block grant, redirected institutional funds and funds allocated as a result of court decrees.
	Child Welfare	Title-IVB (family preservation),Title IV-B foster care services, Title IV-E (adoption assistance, training, administration) and technical assistance and in-kind staff resources
	Juvenile Justice	Federal formula grant funds to state for juvenile justice prevention, state juvenile justice appropriations, and juvenile courts
	Education	Special education, general education, training, technical assistance, and in-kind staff resources
	Governor's Office/Children	Special children's initiatives, often interagency blended funding
	Social Services	Title XX funds and realigned welfare funds (TANF)
	Bureau of Children w/ Special Needs	Title V federal funds and state resources
	Health Department	State funds
	Public Universities	In-kind support, partner in activities
	Department of Children	In states where child mental health services are the responsibility of child agency, not mental health, sources of funds similar to above
	Vocational Rehabilitation	Federal and state-supported employment funds
	Housing	Various sources
Local	County, City, or Local Township	General fund
	Juvenile Justice	Locally controlled funds
	Education	Court, probation department, and community corrections
	County	May levy tax for specific purpose (mental health)
	Food Programs	In-kind donations of time and food
	Health	Local health authority – controlled resources
	Public Universities/ Comm. Colleges	
	Substance Abuse	In-kind support
Private	Third Party Reimbursement	Private insurance and family fees
	Local Businesses	Donations and in-kind support
	Foundations	R. W. J., Casey, Soros Foundations, various local foundations
	Charitable	Lutheran Social Services, Catholic Charities, faith organizations, homeless programs, and food programs (in-kind)
	Family Organizations	In-kind support

Koyanagi, C. & Feres-Merchant, D. (2000). For the long haul: Maintaining systems of care beyond the federal investment. *Systems of care: Promising practices in children's mental health, 3*. Washington, DC: American Institutes for Research, Center for Effective Collaboration and Practice.

Diversified Funding Sources and Approaches for Family Organizations

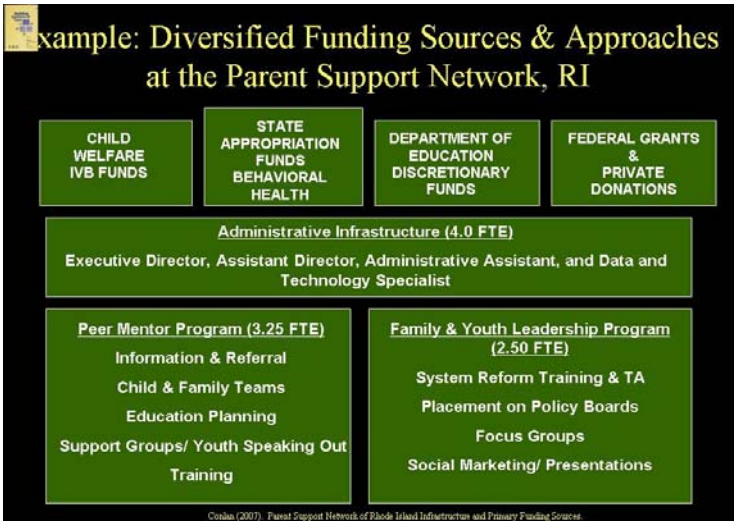
Financing for family and youth-run organizations needs to be treated as a "cost of doing business" in systems of care. The Rhode Island Parent Support Network provides one example of a family-run organization that is drawing financing from multiple state agencies serving children and families.

Trainer's Notes

You might want to share other examples of system of care initiatives that are drawing on diverse funding streams.

Example: Diversified Funding Sources & Approaches at the Parent Support Network of Rhode Island

SLIDE 38 (183)



Parent Support Network of Rhode Island (PSN) is an example of a family-run organization that has been able to diversify its funding base and support a number of programs that are directed and implemented by the families and youth. PSN started as a small project out of the Mental Health Association in 1986 and then became an independent 501(c)3 nonprofit by 1993 with the support of a Federal statewide family network grant. PSN learned early that key to building its funding base was the ability to build relationships across state systems serving children, youth and families. PSN worked creatively to utilize funding sources in the state to implement family and youth directed programs and activities. A major need identified by families and youth was to have a peer that could provide support at an individualized child, youth and family level and help youth and families work with education, behavioral health, child welfare, juvenile justice, and other systems to receive necessary services and supports and preserve the family. PSN has been able to utilize child welfare Title IV-B funding, state appropriations allocated to the Department of Children, Youth and Families, Department of Education discretionary funds, and private foundations to support its peer mentor program. The peer mentor program provides: ongoing information and referral with a toll-free helpline; support for families involved in child welfare; support through the wraparound and education planning processes; ongoing education and individualized advocacy training; and family and youth directed support groups.

In addition, PSN has been able to develop new positions, programs and approaches with federal grant dollars that, for the most part, have been

Trainer's Notes

It is most effective for the parent co-trainer to present this slide and provide other examples of funding sources and approaches for family-run and youth organizations

sustained with state appropriation funds based on producing successful outcomes for children, youth and families. This has included: the development of the "Youth Speaking Out" youth group; a family and youth leadership program; available participant supports for families and youth to participate on policy boards and trainings; implementation of ongoing focus groups; and, conducting public awareness activities.

In building a diversified funding base, PSN has learned that it is important to have a sound administrative infrastructure that includes: management leadership; supervision; administrative support; fiscal and management information system and technology; and staff capacity needed to support the ability to take on new funding opportunities and programs.

Medicaid Strategies

SLIDE 39 (184)

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

Medicaid Option	*Advantages*	*Issues*	*Example*
Rehabilitation Services Option	•Flexibility to cover a broad array of services and supports provided in different settings (e.g., home, school)	•Service definitions often adult-oriented •Provider-service mismacth	•OH – developing new service definitions and case rates for intensive home-based services and Multisystemic Therapy
Managed Care Demos and Waivers - 1115 and 1915 (b)	•Accountability and management of cost through risk structuring/sharing •Flexibility to cover wide range of services and populations	•Managed care not without risks/challenges •Federal waiver process can be challenging •Cost neutrality issues	•NM – covering Multisystemic Therapy •AZ – covering family support and urgent response for child welfare
Home and Community-Based Waivers - 1915 (c)	•Flexibility, broader coverage, waiver of income limits and comparability	•Alternative to hospital-level of care but PRTF (i.e., residential tx.) may be issue •Cost and management concerns/limited to small number	•KS, NY, VT, IN, WI – have HCBS Waivers •AK, FL, GA, IN, KN, MD, MS, MT, SC, VA – have community alternatives to psychiatric residential treatment facilities demonstration grant

Pires, S. 2005. *Building systems of care.* Human Service Collaborative. Washington, D.C.

Medicaid provides a number of options that states can use to fund appropriate health and behavioral health services for children involved or at risk for involvement in child welfare and, sometimes, for family members, depending on eligibility and benefit design. There are pros and cons associated with these options, which need to be analyzed as part of a strategic financing approach to systems of care. These include:

- The Rehabilitation Services Option, which allows flexibility to cover a broad array of home and community services, but caveats are that service definitions are often adult-focused and need to be customized for children and youth; many states use the Rehab Option, but covered services vary from state to state;
- Managed care 1115 and 1915(b) demonstrations and waivers, which also allow flexibility to cover a broad array of services and supports, although the Federal waiver process can be

Trainer's Notes

The following four slides allow the trainer to spend a little more time on Medicaid as a critical financing stream for children and families in child welfare. Point out to participants that all Medicaid options and strategies have pros and cons, and analysis of these needs to be part of strategic financing approaches in systems of care. Also point out that Medicaid State Plans vary from one state to another.

challenging and managed care needs to be implemented carefully, with customized approaches for children and families in and at risk for involvement in child welfare, such as risk-adjusted rates and coverage of appropriate services;

EXAMPLE

New Mexico and **Arizona** are examples of states using managed care waivers that include evidence-based and effective services for the child welfare population, such as Multisystemic Therapy and family support services, and Arizona, to guard against under-service, also incorporates a risk-adjusted rate (i.e., a higher payment) into its managed care system for children involved in child welfare, recognizing their higher service utilization needs. The Arizona managed care system also has built an urgent response system for children coming into care in child welfare.

- Home and community-based waivers (1915 c), which allow flexibility to cover populations, as well as types of services, not covered in a state's Medicaid plan, but which can be used only for those who would otherwise be in an institutional (i.e. hospital) level of care, not currently including residential treatment facilities; however, the federal Medicaid agency is funding demonstrations of home and community-based waivers as alternatives to psychiatric residential treatment facilities, which is an opportunity for some states to utilize Medicaid to fund more community supports for children in child welfare and other populations;

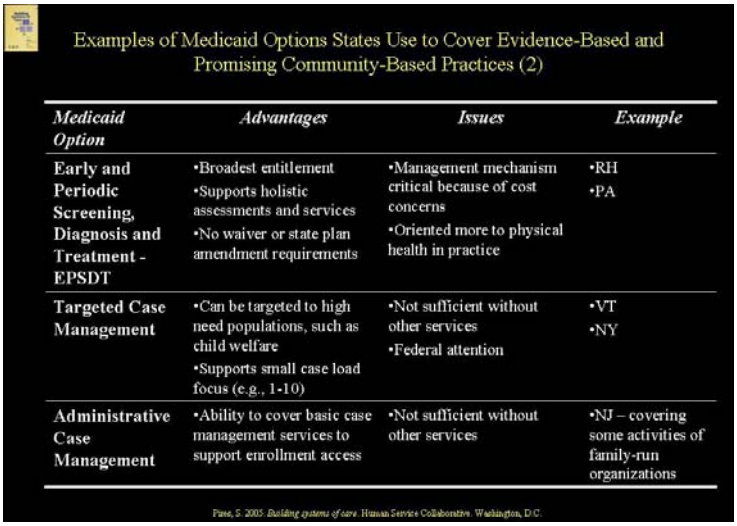
EXAMPLE

A number of states, such as **New Jersey** and **Minnesota**, have HCBS waivers for children with chronic physical or developmental disabilities; a smaller number, such as **Kansas, New York, Vermont, Indiana** have HCBS waivers for youth with serious emotional disorders**; Wisconsin's** HCBS waiver covers primarily children with autism. Ten states have Centers for Medicare and Medicaid "PRTF" demonstration grants, which are testing home and community based waivers for psychiatric residential treatment facility (PRTF) alternatives; these include: **Arkansas, Florida, Georgia, Indiana, Kansas, Maryland, Mississippi, Montana, South Carolina, and Virginia.**

Trainer's Notes

You may want to add other examples, from your own experience, that illustrate various Medicaid option approaches.

SLIDE 40 (185)



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

Medicaid Option	*Advantages*	*Issues*	*Example*
Early and Periodic Screening, Diagnosis and Treatment - EPSDT	•Broadest entitlement •Supports holistic assessments and services •No waiver or state plan amendment requirements	•Management mechanism critical because of cost concerns •Oriented more to physical health in practice	•RH •PA
Targeted Case Management	•Can be targeted to high need populations, such as child welfare •Supports small case load focus (e.g., 1-10)	•Not sufficient without other services •Federal attention	•VT •NY
Administrative Case Management	•Ability to cover basic case management services to support enrollment access	•Not sufficient without other services	•NJ – covering some activities of family-run organizations

Pires, S. 2005. *Building systems of care*. Human Service Collaborative. Washington, D.C.

- The Early Periodic Screening, Diagnosis and Treatment (EPSDT) program, which is the broadest entitlement to services for children and youth, ages 0-21, and requires periodic screens and provision of medically necessary services, even if those services are not included in a state's Medicaid plan; however, in practice, EPSDT is implemented primarily with respect to physical health issues (even though Federal law requires inclusion of behavioral health screens and services if needed); also, because of the broad nature of EPSDT, cost concerns are an issue, requiring effective utilization management. EPSDT, however, is a very appropriate vehicle for screening children involved or at risk for involvement in child welfare and linking them to appropriate physical and mental health services, and the courts have recognized this.

EXAMPLE

Examples of states and localities in which the courts have ruled in favor of plaintiffs bringing EPSDT lawsuits, including for children in child welfare, are **Massachusetts**, **Los Angeles County**, and **Pennsylvania**.

- Targeted case management, which can be targeted to high need populations, such as children in child welfare, but which is not sufficient without other services being available; also, the federal Medicaid agency is scrutinizing targeted case management for children in child welfare to ensure that it is not being used in lieu of child welfare case management (i.e., as a cost shift to Medicaid);

Trainer's Notes

Provide examples with which you are familiar of states using these various options.

EXAMPLE

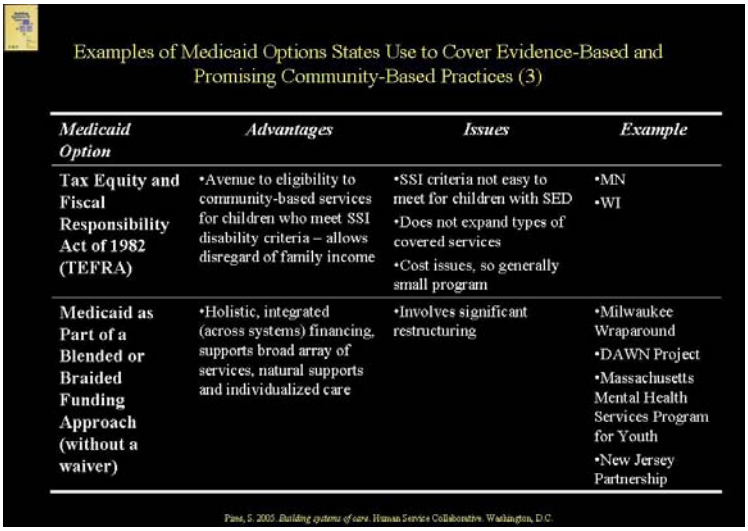
Vermont and **New York** are examples of states that utilize targeted case management.

- Administrative case management, which can be used to help families access and coordinate services, but which is not sufficient without other services being available;

EXAMPLE

New Jersey is an example of a state that is using administrative case management dollars to fund some of the activities of family-run organizations, including linking families in child welfare to appropriate entitlements.

SLIDE 41 (186)



- Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) provision, allowing coverage for youth with physical, developmental and behavioral health disabilities who can meet Supplemental Security Income (SSI) disability criteria whose families exceed the income levels of Medicaid eligibility, but does not expand array of services; cost concerns are an issue so often TEFRA is limited to a small number of youth, and, in any event, many youth with serious behavioral health disorders have difficulty meeting the SSI disability criteria; however, even with these constraints, TEFRA is an important vehicle for covering children whose families might otherwise have to relinquish custody to child welfare to access health or mental health care;

Trainer's Notes

You may want to share other examples of states that have used various Medicaid options to prevent families from having to relinquish custody to access services.

EXAMPLE

Minnesota and **Wisconsin** are examples of states that have the TEFRA option.

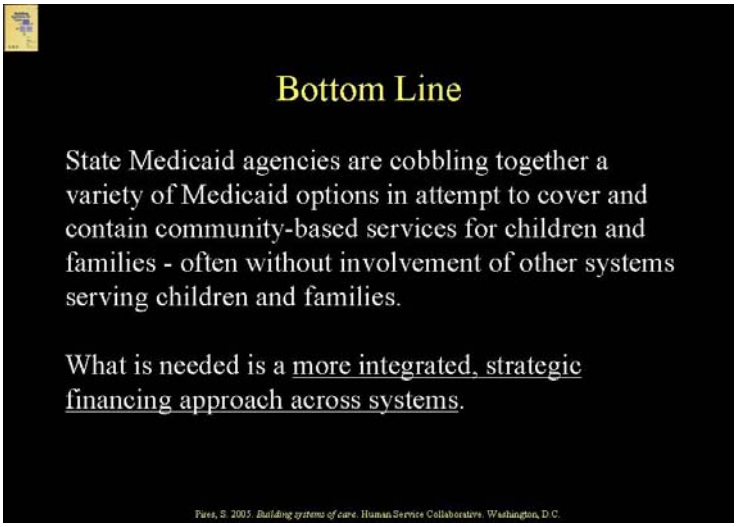
- Medicaid as part of a blended or braided funding strategy, which allows for the most flexible provision of an integrated array of services and supports, but involves significant restructuring of financing and accountability mechanisms (and must still ensure an "auditable" trail for Medicaid purposes).

EXAMPLE

In **Milwaukee, Wisconsin,** Milwaukee Wraparound is an example of a blended funding approach using Medicaid dollars.

Need for Cross-System Financing Strategy

SLIDE 42 (187)



The "bottom line" is that states are cobbling together a variety of options to cover and contain home and community-based services under Medicaid and that an overarching strategic financing plan, which crosses systems serving children and families and involves child welfare stakeholders, often is missing.

Trainer's Notes

This returns us to a point made earlier that State Medicaid needs to be a partner in system of care efforts.

First Steps

SLIDE 43 (188)

There are a number of questions that need to be answered as the first steps in a strategic financing approach, including: identifying the population(s) of focus; agreeing on underlying values and intended outcomes; identifying needed services and supports and the practice model; identifying how services will be organized (e.g., how will families access them, how will children be screened, assessed and linked to services and supports, etc.); identifying the infrastructure to support the delivery system (e.g., system management; training and capacity building; family and youth partnership); costing out the system of care.

Trainer's Notes

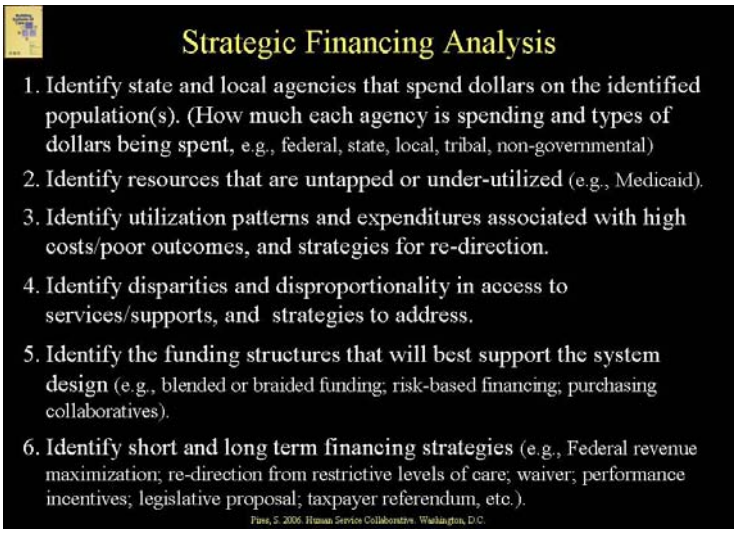
Resources related to strategic financing for systems of care include:

A Self-Assessment and Planning Guide: Developing a Comprehensive Financing Plan, available from: http://rtckids.fmhi.usf.edu/study03.cfm.

"Steps for Implementing a Refinancing Initiative", Appendix J of *Building the Infrastructure to Support a Child Welfare Driven System of Care: A Guide for Communities,* available from:

Steps in a Strategic Financing Analysis

SLIDE 44 (189)



Steps in a strategic financing analysis include:

- mapping the state and local agencies that spend dollars on the identified population(s), how much they are spending and on what;
- identifying resources that are untapped, such as Medicaid dollars (for example, if the child welfare system is spending 100% general revenue to buy services that could be paid for by Medicaid);
- identifying utilization and expenditure patterns associated with high costs or poor outcomes (for example, large expenditures on out-of-home placements or on psychiatric and psychological evaluations that do not lead to individualized, strengths-based, solution-focused interventions);
- identifying disparities and disproportionality in access to services and supports (for example, racially and ethnically diverse children and families involved in child welfare and overrepresented in out-of-home placements);
- identifying funding structures that will best support goals (such as blended funding);
- identifying short and long term financing strategies, such as re-directing spending from out-of-home placements to community-based care or garnering support for a taxpayer referendum to generate new dollars for early intervention for children and families at risk of child welfare involvement).

Trainer's Notes

You may want to share examples from your own experience of states or communities that have undertaken these types of steps in a strategic financing analysis.

Tools to Support Families and Staff

A program budget, as opposed to a line item budget, gives a much clearer picture of what a system of care is actually doing, and thus is a good strategic tool for system builders to use with stakeholders – to educate, plan, and strategize. It can help to de-mystify cost and financing issues.

The following illustration describes a program budget for a neighborhood system of care, in which a Family Resource Center served as a hub for services and supports to neighborhood families, including those in or at risk for involvement in child welfare. In this progam budget, line item costs – personnel, equipment, etc. – are cross-walked to program categories. This makes it clearer to stakeholders for what activities dollars are being spent and whether expenditures reflect the values and goals of the system of care. So, for example, a good percentage of the dollars here are being spent on services to families and on family leadership – both of which are indeed priorities. The second half of the table shows, not expenditures by program category, but revenue by category. This gives stakeholders a picture of which program areas may be too dependent on one funding source; in this example, the school linkages program is almost entirely dependent on one grant source. If that source were to disappear, school linkages would be likely to disappear as well. A program budget can help stakeholders think strategically about tying financing strategies to their priorities.

Trainer's Notes

The next three slides refer to tools that support families, staff and other stakeholders in becoming more knowledgeable about and involved in financing. The first addresses the usefulness of a program budget.

You might want to share other budgeting/financing tools that system builders can use that help to de-mystify cost and financing issues for families, staff and other stakeholders.

SLIDES 45-46 (190-191)

Program Budget for a Neighborhood-Based System of Care

Cost Categories	Proposed Total Costs	Neighborhood Governance	Family Leadership	Family Service & Support	Removal of Barriers	Community Organizing	School Linkage	Tracking and Evaluation	Volunteers	Partnership Building	Exec. Direct. & Support
Personnel Salaries	446,000	21,000	29,000	190,000	21,000	26,000	35,000	15,000	30,000	18,000	63,000
Fringe	133,000	6,300	8,700	57,000	6,300	7,800	10,500	3,900	9,000	5,400	18,900
Building Occupancy	93,600	8,700	12,300	36,800	2,400	4,300	4,000	2,500	4,300	2,500	15,800
Professional Services	109,000	17,600	22,100	32,400	3,600	2,700	2,700	18,600	2,700	2,900	3,700
Travel	43,700	12,300	5,300	10,300	9,000	1,200	3,000	500	500	500	1,600
Equipment Costs	6,000	600	600	600	600	600	600	600	600	600	600
Food Services	25,000	0	4,000	1,000	18,000	0	1,000	0	1,000	0	0
Subcontracted	89,000	0	0	89,000	0	0	0	0	0	0	0
Insurance	13,500	2,700	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200
Operating Supplies & Expenses	21,500	1,800	700	8,600	200	1,300	2,100	500	1,500	4,100	4,100
Other (Parent stipends, transportation, child care)	84,000	0	40,000	9,000	35,000	0	0	0	0	0	0
Equipment Lease	25,000	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500
Property	25,000	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500
GRAND TOTAL	1,115,100	80,000	125,900	459,900	84,300	51,100	64,100	45,800	55,300	36,800	113,900
Revenue Totals Across Sources	Revenue Allocation by Program										
Foundation	217,100	40,000	30,000	25,000	28,300	24,000	0	22,800	12,000	15,000	20,000
ADM–State	258,800	2,500	28,400	157,900	3,000	20,000	0	5,000	12,000	5,000	25,000
County–CFS	124,900	20,000	30,000	30,000	10,000	5,000	0	3,000	12,000	2,000	12,900
DOE	70,100	2,500	1,600	0	0	0	60,000	0	0	0	6,000
Family Preservation Grant	373,400	5,000	20,000	230,000	35,000	0	0	12,000	18,000	14,000	39,400
In-Kind	29,300	0	10,000	10,000	5,000	1,00	0	0	800	0	2,500
Donations	21,300	5,000	900	5,000	1,000	100	2,100	3,000	500	800	5,000
Other Grants	20,200	5,000	900	5,000	1,000	100	2,100	3,000	0	0	3,100

Pires, S. 2000. *Program budget for a neighborhood-based system of care.* Washington, DC: Human Service Collaborative.

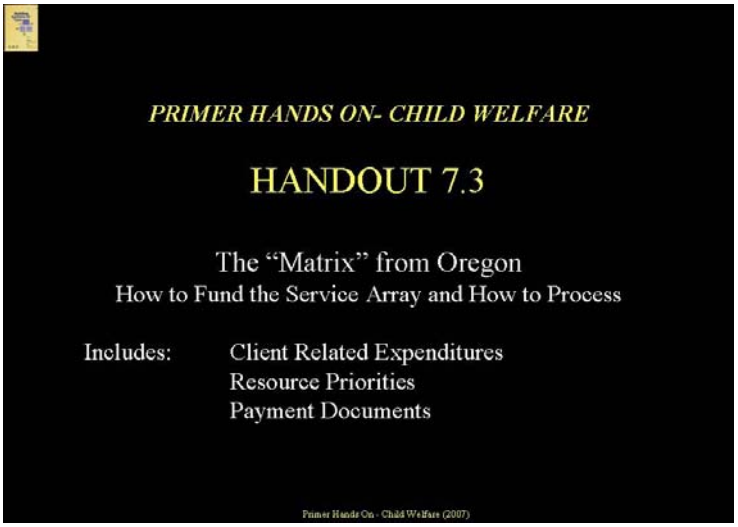
Families, youth and culturally diverse constituencies need to be active and informed partners in the development of financing strategies. The more these key stakeholders know about funding streams and the politics around them, the more effective they can be in advocating for needed changes. More importantly, funding priorities and the strategies to support them should be driven by the strengths and needs of those most affected by them. Financing viewed through a multicultural lens may lead system builders to strategies "outside the box". For example, a strategy being used by some Family Resource Centers is built around the concept of "reciprocity", where there is no monetary fee for services, yet all participants "contract" for services by agreeing to provide volunteer hours through a "Time Dollar Bank" to support the agency.

Trainer's Notes

Information about Time Dollar Bank can be found at: **www.timedollarinstitute.org**

SLIDE 47 (192)

Trainer's Notes



This example, from Oregon's System of Care, provides an easy chart for field staff on "how to pay" for services.

EXAMPLE

Oregon's Cost Center and Object Code Matrix provides an easy chart for field staff on "how to pay" for services.

HANDOUT 7.3

Handout 7.3 is an example of "The Matrix" from **Oregon's System of Care**. The matrix provides a list of Child/Family Related Expenditures: such as Goods (clothing, food, etc.); Home Related Services (client home repairs, housing, etc); Legal Services (guardianship/custody/adoption); Transportation (out of state and instate, gas vouchers, per diem, etc.); Education (classes, school supplies); Social/Treatment Services (counseling, mentoring, day care, etc.); and, Medical/Health (psychological evaluations, drug testing, etc.). The Matrix then provides guidance on "how to fund the service array", relying on family or relative resources first. Funding sources include such sources as: non-profit community resources, Oregon Health Plan, county mental health, central adoptions funds, Foster Care Prevention funds, IV-E Waiver, flex funds, etc. Lastly, the Matrix provides guidance on "how to process" the payment from the quickest (i.e., expense voucher) to the most restrictive (i.e., contract) methods.

Refer participants to Handout 7.3 "The "Matrix" from Oregon's System of Care – How to Fund the Service Array and How to Process.

TEAM WORK (Team Meeting #3)

You will now have an opportunity to work within your respective teams to address a number of questions with respect to your case scenarios, which represent your system of care sites. The team meeting is an opportunity for you to apply didactic material from *Primer Hands On-Child Welfare,* as well as your own knowledge and experience, to a strategic analysis of system of care issues and challenges. In the course of your team meeting, you need to designate a recorder and lead "reporter" to report back to the large group after the team meeting. Your team is free to add details and particulars to your case scenarios, as long as all team members agree on them, and they are within the realm of possibility. In some cases, your "system of care" may not yet have a given structure in place, in which case your strategies will be geared toward developing, rather than improving, that structure. Teams need to be creative and strategic as they wrestle with the following questions:

1) How have we structured the array of services and supports (or benefit design)? What are the strengths and shortcomings in our current array of services and supports? How does our service array incorporate partnership with families and youth, and what makes the structure culturally competent? What strategies can we implement to improve our benefit structure/service array? What are the pros and cons of these strategies?
2) How have we structured financing? What are the strengths and shortcomings of our current financing structures and strategies? How do our financing structures and strategies incorporate partnership with families and youth, and what makes them culturally competent? What strategies can we implement to strengthen the financing for our system of care? What are the pros and cons of these strategies?

Report Back and Large Group Discussion

The designated reporter from each team reports back to the large group, providing a concise summary of the team's deliberations, how the team answered the questions posed, and the team's observations on its own group process. Each team has 10 minutes for this report. After each team reports, the large group has the opportunity to weigh in with observations that can add to understanding about both the process and the strategic work undertaken by the team. The team meetings and large group discussion provide an opportunity for peer learning and exchange, taking advantage of the collective "best thinking" of participants.

Trainer's Notes

Team Meeting and Report Back Session

Method
Team work and Large Group Discussion

Training Aids
Flip charts with markers (one chart for each table); Case Scenarios U, S, A

Approximate Time
1 hr. 45 min. (for both team work and group discussion)

Goals
Participants will work within their respective teams to address a number of questions with respect to their case scenarios, which represent their system of care sites.

Remind participants that in some cases, a team's "system of care site" may not have structured a particular function. Encourage team members to develop appropriate structures and strategies in these cases. Also, advise them that they are free to add details to their case scenarios as long as all members of the team agree to them, and they are within the realm of possibility.

Report Back and Large Group Discussion -
Explain that the designated reporter from each team will report back to the large group, providing a concise summary of the team's deliberations. The trainer(s) facilitate this discussion, offering their own observations as well.

By the third team meeting, participants generally have become very familiar with their respective system of care communities and creative about proposing

strategies to move the system-building effort forward. You can reinforce concepts discussed in the didactic presentation by relating concepts to points made by each of the teams as they report back, as well as by raising points, if there is a need to augment the discussion. Some ideas to pull out from the case scenarios include:

In Metro, there are large numbers of youth in out-of-home placements across all the systems. All the systems – and the state, which pays for many of these placements, have an incentive to re-direct spending from out-of-home to community supports. The schools also have this incentive as they are spending a lot on out-of-school placements. Metro has a lot of services and supports; a problem is that they are not organized into any coherent delivery system for youth in transition.

Unlike Metro, Fairview County is spending a lot of its own money (not the state's) on services to children and families. It has sophisticated providers, but they are not necessarily providing the array of services and supports that are needed, and there has not been a lot done to systematically develop natural helping networks, which could be key to engaging newly arrived families. System builders could work closely with the provider community to build their capacity to adopt a system of care practice model and then work with state agencies (child welfare and mental health) to give providers the financial flexibility to implement a system of care approach.

In the Heartland, child welfare and substance abuse are trying to implement this initiative basically on their own. Yet, their own research indicates the multi-systemic needs of the families they are targeting, including for basic daily living supports and social supports. While this is a rural area without a lot of money, there are resources, through faith-based organizations, public libraries, primary care providers, welfare offices, etc., that could be mobilized to help support this effort. In addition, many of these families could be Medicaid eligible; these system builders should look closely at the Medicaid benefit to see how it might cover effective practices like the Matrix Model.

LUNCH WITH AFFINITY GROUP

You have the opportunity to lunch with your peers, for example, families may wish to eat together, or state-level representatives, providers, local-level representatives, youth, etc.; designated tables are set up for this purpose.

Lunch with Affinity Group
1 hour

This structure allows participants to lunch with their peers, for example, families may wish to eat together, or state-level representatives, providers, local-level representatives, youth, etc. Provide place cards on tables letting participants know which table is designated for which group.